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

Marty Beyer, PhD
Mental Health Monitor

And

David W. Roush, PhD
Protection from Harm Monitor

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INDIVIDUAL FACILITY MONITORING REPORT:

TABERG RESIDENTIAL CENTER FOR GIRLS

Taberg, NY

I. INTRODUCTION

This is the fifteenth 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 September 24-26, 2013. 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 Psychotropic's, Staff Training on Psychotropic Medications and Psychiatric Disabilities, Psychotropic Medication Refusals, Informed Consent, Treatment Planning, Substance Abuse Treatment, Transition Planning, Document Development and Revision, and Quality Assurance Programs.

A. Facility Background Information

Taberg is a 23-bed limited secure facility for girls with two units in one building. Another building contains a gymnasium and library, and the school is in the Annex off-grounds. 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. With all the YDA positions continuing to be filled, the strong leadership of the Director and cohesive unit teams provide a stable environment for residents and staff.

On September 24, 2013, there were 19 girls in residence at Taberg (with three additional girls in jail pending assault charges at Taberg, one for a group attack on a resident and two for staff injuries). Eight were designated for the mental health unit. Seven girls at Taberg were there during the monitoring visit six months previously (one of whom is now at the jail); three of these girls were discharged after the last site visit and returned to Taberg before this site visit.

The 19 girls ranged in age from 12 to 17. The immaturity of the 12-year old and the three 13-year olds is a significant challenge, especially since more than half the girls are 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 19 girls had been at Taberg from 19 days to 341 days; this average length of stay of 114 days is two weeks longer than the Taberg average in the last site visit. Seven had been there two months or less and six had been there five months or longer. Two girls came in two days apart, and then a week later three girls came in on the same day (two 13 year olds and 14 year old)—this scheduling of the five most recently arrived youth must have presented challenges in maintaining unit stability.

The 19 Taberg girls have been sentenced for: Assault (6), Criminal Mischief (3), False Report (2), Manslaughter (1), Robbery (1), Attempted Assault (1), Possession of a Weapon (1), Grand Larceny (1), Petit Larceny (1), Menacing (1), and Obstructing Government (1).

Fourteen of the 19 Taberg girls have psychiatric diagnoses, and most have more than one: ADHD (2), Anxiety (2), Bipolar (1), Depression (1), Mood Disorder (6), PTSD (4), Impulsivity (1), and Insomnia (4). One girl is diagnosed with Conduct Disorder. Five girls, four of whom had just arrived, had no diagnosis.

Fourteen of the Taberg girls are prescribed psychiatric medication: Celexa (3), Clonidine (3), Depakote (1), Effexor (2), Intuniv (2), Lamictal (1), Melatonin (1), Prozac (1), Risperdone (2), Seroquel (2), Topomax (1), Trazodone (4), Vistaril (1), Zoloft (3), and Zyprexa (1). The number of girls prescribed Seroquel at Taberg decreased substantially since the previous site visit.

Nineteen girls were discharged from Taberg between 3/5/13 and 8/29/13. The average length of stay of the 14 of those girls who were discharged from Taberg to Community Multi-Services Offices (CMSOs) was six months (a month less than the average of the released girls reported in the last site visit); one of those girls was released to the Utica CMSO after 4.5 months at Taberg, returned 12 days later and was discharged again to the CMSO two months later. Four girls were released to residential programs (House of the Good Shepherd, Madonna Heights, SCO, and St. Joseph). One girl, who had been at Lansing 10/12-1/13, then returned and was discharged 7/2/13 after two months when Lansing closed, was revoked on aftercare, sent to Taberg on 8/1/13, and returned to the Syracuse CMSO on 8/8/13. One girl who had come from Lansing was fennered from Taberg to Columbia where she remains. She was fennered in 7/13 due to "repeated threats, acting out behaviors and refusal to engage therapeutically confirm our assertion that she is inappropriate for the level of care at a Limited Secure facility." She had numerous Level 3 rule violations (4/11, 4/15, 4/25, 4/26, 5/6, 5/7, 5/20, 7/11), 12 restraints and was charged for assaulting a staff member. "Her lack of control and assaultive behaviors require a higher level of supervision and care than available at a typical Limited Secure Facility. She needs an environment that can provide a greater degree of control and security to prevent her from further assaultive and aggressive behaviors. She needs a placement that can provide her with anger management counseling to address her complete lack of anger control."

B. 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 QAI Report from the Quality Assurance and Improvement (QAI) Bureau in advance of the monitoring visit.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS) data. The Monitors were given OCFS' fifth Six-Month Progress Report on the Master Action Plan (MAP) on June 13, 2013.

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. These comparisons confirmed the accuracy of the data findings of the QAI Report, even though it included a different period of time.

3. Entrance Interview

The entrance interview occurred on September 24, 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; Andre Cuda, LMSW II; Scott Diego, Youth Counselor (YC) 1; Edgardo L. Lopez, Settlement Agreement Coordinator; Paul Piersma, YC1; Monique Thomas, Assistant Counsel; Dr. Joe Tomassone, Chief of Treatment Success; and Suzanne Tulino, Facility Director.

4. Facility Tour

Walkthroughs of the facility occurred throughout the visit.

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, one Mental Health Rounds, two DBT groups, a Sanctuary group, an Innervisions and a Triad substance abuse groups, met with the Therapeutic Intervention Committee (TIC), met with the clinicians/coaches, and reviewed 10 residents' records

6. Staff Interviews

The Monitors interviewed 17 Taberg staff. In addition to group meetings with staff, the MH Monitor interviewed two clinicians, a nurse, a YC, and a Youth Division Aide (YDA). The PH Monitor interviewed three (3) YDAs, one Facility Director, three nurses, one regional nurse administrator, one Bureau of Training (BOT) trainer, one Administrator on Duty (AOD), and two Youth Counselors 2.

7. Resident Interviews

The MH Monitor interviewed three (3) girls, and the PH Monitor interviewed nine (9) girls with an average age of 14.9 years. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on September 26, 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: Amy Carey, Teacher; Sandra Carrk, Project Manager; Al Clarke Teacher; Dan Comins, Facilities Manager; Andre Cuda, LMSW II; Dave DeLaOsaCruz, YC 1; Scott Diego, YC1; William Gilman, SWII; Donna Leonard, Nurse II; Mike Levandronck, LMSW II; Edgardo Lopez, Settlement Agreement Coordinator; Kelly Miller, Education Coordinator; Amy Ony, Teacher IV; Norm Pure, Sanctuary; Karen Renwrik, Nurse III; Ron Rutledge, ATT; Debra Skinner, Teacher IV; Ryan Smith, YDA3; Sam Spina, YDA3; Josh Stockbridge, YDA3; Monique Thomas, Legal; Dr. Joe Tomassone, Chief Treatment Services; Sue Tulino, Facility Director; and Bruce Warcup, YDA 3. Participating by teleconferencing were Sean Allen, Bureau of Training; Jim Barron, Director Labor Relations; Merle Brandwene, Director Management and Program Support; Matt Carpenter, Executive Assistant to DJJOY Deputy Commissioner; Erin Cassidy, Executive Assistant to Executive Deputy Commissioner; Lori Clark, Quality Assurance Specialist; Dr. Michael Cohen, Medical Services Director; Diane Deacon, Legal; Myra DeLuke, Quality Assurance Specialist; Felipe Franco, DJJOY Deputy Commissioner; Larry Gravett, Director SIU; Tony Hough, DJJOY Associate Commissioner; Pam Kelly, Director Bureau of Training; Jennifer Mack, Quality Assurance Analyst; Beth McCarthy, Bureau of Training; Rob MacGiffert, Assistant Director QAI; David Nasner, Behavioral Health Services; Ines Nieves, DJJOY Associate Commissioner; Denise Passarello, Quality Assurance Specialist; Sheila Poole, OCFS Executive Deputy Commissioner; Lee Prochera, Deputy Counsel; Mike Rotolo, Quality Assurance Analyst; and Jenne Utting, Quality Assurance Specialist.

C. Preface to Protection from Harm and Mental Health Findings

Everyone at Taberg is benefitting from the opening of the Annex which not only provides an expanded school area but also private meeting space for support teams; clinicians and the AOD also have offices in the Annex along with an EBP room and a comfort room, and groups meet there as well. With the opening of the Annex, there is 100% school attendance—the residents were described as happier to go school, getting in vans everyday with their backpacks; they have had no security problems with movement.

In addition, the pottery studio is nearly ready to open with instruction to be provided by a local artist. Taberg currently has four other program enhancements: arts and crafts, cosmetology, culinary (a local chef/restaurant owner takes residents through the process of preparing a meal), and an education work station (graphic arts certificate).

For the most part, staff stability continues to be a strength at Taberg. All the YDA positions are full (only one staff person was out on worker compensation, compared to 18 in the past) and stable and the same YCs, teachers, and nurses continue. However, both the Assistant Director for Programs and the Assistant Director for Treatment remain unfilled, although a current YC and clinician may be designated acting in those positions soon. Getting a replacement YC may happen quickly, but recruiting even a temporary to fill the clinician's role will be difficult. Meanwhile, the only psychologist at Taberg resigned at the end of the summer due to the new OCFS expectation that clinicians work every weekend and finding a replacement for her will be a challenge. Two new clinicians, both social workers, have started at Taberg since the last site visit to fill previously vacant positions.

Taberg is at the point of establishing an administrative team, which will provide improved stability and continuity. The designation of Mr. Diego and Mr. Cuda as the Assistant Facility Directors for Programs and Treatment, respectively, still needs to be approved so that replacements can be recruited for their vacated positions. Having the Assistant Director positions filled will reduce the administrative burden on Ms. Tulino. These individuals seem to work well together and have the support of the staff that they will be supervising. However, neither individuals have prior experience in these positions, so when combined with the newness of Ms. Tulino in the leadership role, the administrative team is relatively inexperienced. Nonetheless, the positive factors associated with all three predict substantial improvements for Taberg.

The QAI Review of Taberg commended two YDAs for their group facilitation skills, two YCs (one for establishing a consistent sense of unit management and one for JJIS contact notes and providing strong support to residents), and a clinician for group facilitation skills.

II. PROTECTION FROM HARM MONITORING

Taberg has made substantial progress with the implementation of CPM and the New York Model. There were noticeable improvements as described by youth and staff. Additionally, the institutional climate has improved, and the atmosphere in the living units and school annex is a much calmer.

The Annex is another asset to the future of program improvements. Moving the school program to the Annex seems to have produced positive results for youth by providing a different space and a transition between the residential unit and the school. The school now looks and feels like a school, and staff reported that the youth are responding appropriately. Since the education program moved to the Annex, school attendance has increased dramatically.

Youth perceptions of safety have improved. When the nine (9) youth interviewees were asked to rate their personal safety on a scale of 1 to 10 with 10 being the highest, their average response was 8.44. This is a seven percent (7%) increase from the March 2013, monitoring visit. When asked what more could be done to improve resident safety,

five (5) youth (56%) complained about feeling unsafe because there were too few female staff. (Females constitute 32% of the YDA staff at Taberg according to the information on the organizational chart provided to the Monitors on September 24, 2013, and a shift with no female YDA staff occurred during the monitoring visit.)

Youth spoke very highly of a core group of staff. Of the nine (9) youth interviewees, each said that there was at least one staff member they could go to in times of emotional distress or dysregulation who could help them calm themselves. To be precise, the youth listed multiple staff members as opposed to just one.

In a different way, staffing remains a major challenge. This does not diminish the positive comments about staff from youth or the positive interactions with staff by the Monitors. Instead, there are several other staff whose behaviors are problematic, and these individuals have a negative impact on the progress that the Taberg administration and Home Office are attempting to accomplish. For example, the list of staff on Administrative and Disciplinary Leave seems too lengthy for a facility of this size. Several of the Restraint Packets revealed information about staff behaviors that were highly inappropriate, if not dangerous. Examples can be found in incident number F132324 and Restraint Packets 434810, 442600, and 471098. These incidents have implications for training, Documented Instruction, coaching, and especially corrective actions.

Staffing adequacy at Taberg also continued as an ongoing concern. The numbers of staff available to work a shift have sometimes been unable to maintain the generally accepted professional standard of at least one female YDA staff per shift. As the MH Monitor describes, similar scheduling issues have also resulted in YDAs not being present in Mental Health Rounds and support team meetings despite everyone's interest in having them involved.

A. Use of Restraints

The Monitors endorsed the QAI strategy for addressing variations in the rates of restraints at the DOJ facilities through the establishment of rate thresholds and a system of graduated responses and plans of action. Once this innovative Home Office-designed quality assurance system is fully developed, implemented, and verified, it will serve as a primary safeguard for Protection from Harm issues related to restraints. In the interim, compliance determinations rely on other means of evaluating restraints practices consistent with the language of the Settlement Agreement.

There is agreement that non-compliance (or partial compliance) with Paragraph 41 (Use of Restraints) and Paragraph 42 (Use of Force) should not be determined by increases or decreases in the number of restraints; but the PH Monitor should review existing data on the number and rate of restraints, considering that such information could serve as a "red flag" that undue restraints are occurring. (We make a distinction between the "red flag" situation in this new restraint monitoring approach and the "Red Flag" meeting used in the New York Model to gather staff to discuss urgent concerns about a resident or unit. Even though both may focus on similar restraint activities, the "red flag" monitoring status is a term of the Parties that initiates the shift in the monitoring of restraints.) The determination of a "red flag" situation would prompt a closer inquiry by the PH Monitor in his evaluation of this paragraph and Paragraph 42 (Use of Force). The "red flag" approach

shifts the monitoring logic more toward an inductive versus a deductive approach. The "red flag" restraint monitoring will start with specific observations to detect patterns and regularities that would support broader generalizations and general conclusions related to compliance. The inductive approach involves an accumulation of individual level data elements where the PH Monitor begins with a specific restraint incident and thoroughly reviews the Restraint Packet (the documentation and the video) using each component in each sentence of the Settlement Agreement paragraph as points of analysis along with the restraint evaluation factors articulated in the QAI Report. Once a "red flag" designation is triggered, acquiring a sufficient amount of individual data to reliably establish patterns and regularities in the absence of aggregate data analyses means that a greater number of restraint incidents will need to be included in the monitoring. In other words, to move confidently to a general conclusion under this approach will require an appropriate sampling of restraint events over a designated time, usually the period between monitoring visits. Taberg's restraint frequency and rate data narrowly did not justify a "red flag" designation at the time of the site visit.

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

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

i. Where emergency physical intervention is necessary to protect the safety of any person;

ii. Where a youth is physically attempting to escape the boundary of a Facility; or

iii. Where a youth's behavior poses a substantial threat to the safety and order of the Facility.

COMMENT: The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding.

The Crisis Prevention and Management (CPM) policy and procedure 3247.12 along with PPM 2081.00 and PPM 3247.14 fulfill the requirement that OCFS create a new set of requirements on the use of restraints. During staff interviews, all staff had a working knowledge of the policy and the physical restraint approach. Taberg administration is familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff interviews confirmed a working knowledge of these circumstances.

Taberg staff members are sensitive to restraint rates, especially those situations where staff decisions may inadvertently escalate a youth's behavior versus situations where different decisions would likely have continued de-escalation and, thereby, avoided

a restraint. Administration shows improved sensitivity to the needs of youth and staff in conflict situations, and the quality of coaching and Documented Instruction has also improved. Administration has emphasized coaching and Documented Instruction in situations where staff did not handle the restraint appropriately.

The Restraint Packet reviews also confirmed the perspectives in the QAI Report that there are numerous positive examples of staff using restraints only for behaviors that qualify as reason for restraint. For example, in Restraint Packet 449901, staff responded appropriately. There was sufficient self-injurious behavior, especially head butting the cinderblock wall to justify an intervention. In other words, there were examples of staff using restraints within the parameters set forth in the Settlement Agreement. Similarly, QAI Report showed multiple examples of justified reasons for physical restraint.

The QAI Report is a valuable resource, but it was only one factor in a compliance assessment. From the PH Monitor's perspective, which included information sources different from those used by QAI, the partial compliance determination was because there were still too many examples where the youth's behaviors did not justify physical restraint.

Regarding Restraint Packet 449905, the restraint justification listed on the Administrative Review form was the safety of youth (Paragraph 41, i). One of the Incident Reports indicated that the youth made an aggressive movement toward staff. In another Incident Report, the YDA staff member wrote that another YDA directed the youth to "stop walking away." This "walking away" behavior was noted in a second Incident Report where the staff member indicated that the physical restraint occurred because the youth walked away from the same staff member. A third Incident Report by the primary YDA staff member indicated that the youth refused the staff member's direct order.

Several issues emerged from this documentation. First, a pattern existed in the three Incident Reports where the physical restraint was initiated for "walking away" behaviors, which one of the Incident Reports also described as not following a direct order. The PH Monitor's interpretation of Paragraph 41 is that these behaviors do not automatically qualify as a justified use of physical restraint. Second, a possible alert existed anytime a staff member's restraint justification was for a youth's refusal to follow a direct order. In the PH Monitor's interviews with YDA staff about a youth's failure to follow a direct order, the explanation for how such behavior can move to a physical restraint was based on the perceived need to safeguard the order and safety of the facility (Paragraph 41, iii). While the safeguarding of order and safety within the facility is listed in the Settlement Agreement as a circumstance that justifies the use of physical restraint, OCFS policy omits this justification, preferring instead to make physical restraints justifiable when the youth's behavior was consistent with Paragraph 41 i and ii. OCFS divided Paragraph 41 ii into two different escape attempt categories, one when escape attempts occur on facility grounds and the other when the escape attempts occur off-grounds, so its policy also contains three justifications for physical restraint. The order and safety justification, which is a common rationale for the use of force in many juvenile correctional facilities, is not one of the three reasons that YDA staff can use to justify a physical restraint; but some confusion seemed to exist among YDA staff with respect to an order and safety justification for physical restraints.

In the context of the preceding discussion, the Video Review Form (VRF) for Restraint Packet 449905 raised another question about potential confusion among YDAs regarding a youth's noncompliance. The youth was on a Safety Watch (SW) status, which made her "walking away" behavior a violation of a direct order. When the Incident Reports were compared to the youths current IIP, the contradictory expectations for the youth seemed to have made the situation even more problematic, which will be discussed in greater detail below. An issue existed here that should be referred to the TIC. Do the expected supervisory behaviors of staff for a youth on special status, such as a safety watch or arms length supervision (ALS), become too intrusive or re-traumatizing or act to circumvent a support-team-generated problem-solving approach (IIP) thus resulting in an increase to the youth's anxiety and leading to dysregulation? The documentation provided a rationale to re-examine these status conditions along with a second look at the physical distance or staff proximity required to maintain the youth's safety.

Regarding Restraint Packets 486499 and 486498 (multiple restraints of the same youth on the same day, in this case 17 minutes apart) and regarding justification for the restraints, one restraint documentation (486499, which was the first restraint chronologically despite the higher number on the Restraint Packet) began with an Administrative Review of Physical Restraint notation by the Facility Director that the restraint justification was an "unnecessary restraint." The initial justification by the administrator completing the form was an "emergency to protect the safety of others" (Paragraph 41, i). By the time another restraint occurred (486498), the same justification was used because the youth put a pillow over her room window, and staff then forced their way into her room. When this happened, the Incident Report stated that the youth attacked the staff member who came into the room. (There was nothing in the documentation that suggested the alternative of observing the youth from outside her room, a strategy that has been used effectively in a similar facility.) In entering the room, staff pushed the door over the youth's toe resulting in injury. An SRC referral was made and accepted. The video review on the first restraint confirmed that the staff could have walked away because the youth was not a threat. On the second restraint, the Restraint Monitor Report indicated that the Restraint Monitor arrived after the restraint had begun. One of the YDAs wrote, "Staff try to counsel but she refuses to follow staff directives."

Regarding Restraint Packet 445201, this restraint video started as the youth was getting to her feet following an earlier restraint. The video was consistent with the documentation. An Incident Report stated that the youth was walking away and staff followed and initiated the physical restraint. The video did not show aggressive behaviors on the part of the youth, likewise there were no behaviors to indicate an imminent threat to the safety of the youth or others. The restraint did not meet the reasons in the restraint clause of Paragraph 41. The concern was that a restraint, which did not comport with the reasons for restraint clause, resulted in so much struggling that mechanical restraints had to be applied as a way to calm the youth and resolve the restraint.

Regarding Restraint Packet 476000, at the beginning of the video, three (3) girls were providing assistance to the youth to help her calm down. Staff intervened placing the youth in what appeared to be a loosely applied standing escort. The youth broke free and ran to attack the youth with whom she appeared to have had a problem. The video showed

the staff member falling to the floor with the youth. The restraint did not appear to be justified. The escalation occurred after the failed restraint attempt (one-person standing escort) was administered.

Regarding Restraint Packet 451403, the documentation indicated that the restraint justification was fighting; however, the documentation later described the fighting as "play fighting" or "horseplay." On the video, there were many smiling faces among the youth when the "play fighting" began. However, once the youth moved outside of the camera range, it was not possible to tell what happened. By the time staff intervened, the video revealed two (2) youth in restraints, and both appeared to be upset and struggling against the restraint. This would qualify as a situation where staff supervision appeared to be slow in responding. On the Administrative Review, Facility Director Tulino recommended that SIU look at the video for the 10 minutes before the physical restraint as a way to identify antecedent behaviors and circumstances where staff intervention and de-escalation could have averted the restraint.

Further, the State shall:

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

PARTIAL COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding.

The policy and procedures are established; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. Again, OCFS policies comply with the Settlement Agreement.

Taberg has made progress as a growing proportion of the uses of force appear to be appropriate regarding both the minimum amount of force necessary and in the application of force consistent with the reason for restraint in Paragraph 41. Regarding the use of force, most staff again received good evaluations from youth. For example, 89% of all girls interviewed said that staff use force only when they really need to. Of the nine (9) girls interviewed, six (6) had been restrained recently; but all six (6) (100%) stated that they believed that staff did not try to hurt them during the restraint. In Restraint Packet 486605, the youth placed herself on the floor on her back and began kicking at staff. Even though the incident later required the use of force, here was a good example of increased patience on the part of staff to behaviors that would have previously prompted the use of force.

These findings mark Taberg's progress. The problem is that too many examples existed where staff did not use only the minimum amount a physical control and time in restraints necessary to stabilize the situation. The PH Monitor's findings support the QAI

Report (page 66). In Restraint Packets 451401, 451403, 442599, and 446801, there was time to de-escalate; however, the staff did not use de-escalation techniques and the situations escalated.

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 PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding. 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. The IIP appears to be a Home Office-generated resource to help staff reduce the risk of harm from the use of force by identifying individual risk factors for each youth. Interviews with direct care and health care staff revealed a working knowledge of physical conditions and circumstances that limit the restraints to youth due to heightened risk of physical or psychological harm. However, YDA staff members appeared to pay greater attention to the physical limitations that modify or restrict CPM than to a specific youth's psychological risks from restraint. This seemed to be only a partial application of the guidance contained in the IIP. Further investigation revealed a frequently noticeable gap between the behaviors of staff recommended in the IIP and the behaviors of staff described in the Incident Reports in the Restraint Packets. An unreasonable expectation would be an absolute adherence to the IIP, but greater coherence between the IIP and staff behaviors seems to be reasonable.

Many YDA staff demonstrated effectiveness at de-escalation in ways that did not signal a clear and consistent link with the IIP. The PH Monitor's findings support the QAI Report (page 66). In the review of Restraint Packets 439400, 441399, 442600, and 415400, there were de-escalation techniques used; however, they were not the ones recommended on the IIP. When staff were asked to describe a time when they used a de-escalation technique that helped avoid a restraint, staff stated that it was their relationship with the youth and/or along with de-escalation strategies used throughout each shift. These responses also lacked some direct tie to the IIP. The majority of youth surveyed for the QAI Report also expressed confusion about the IIP, their safety plan, and staff intervention strategies.

Regarding Restraint Packet 449905, YDA staff assessments of the IIP were problematic. This youth's restraint pattern can be instructive to the improved implementation of the New York Model because it exposed some of the gaps where staff did not appear to be working in harmony to help the youth, i.e., where the treatment (mental health) approach and the security/safety (protection from harm) approach did not appear to be on the same page. For example, if a youth were on a special status that required close and proximate staff supervision, but the IIP and/or Safety Plan designated "Time Away" as a preferred method to regain emotional regulation, a conflict existed for YDA staff whose

basic instinct in times of crisis is to err on the side of security. The recommendation is that Home Office re-examine the approach to de-escalation in the context of potential discrepancies between the IIP and/or Safety Plan and the approach by the AOD and YDA staff to maintaining safety and order.

Regarding Restraint Packet 449900, the references to and assessments of the youth's IIP in the documentation for this restraint and for the remaining restraints remained the same. First, the Restraint Monitor Reports, regardless of who was the designated Restraint Monitor, indicated that "Staff adhered to IIP." In all of the documentation, Direct Appeal was noted as a de-escalation strategy, but there was no mention of Direct Appeal in the youth's IIP. Furthermore, the documentation consistently indicated that the IIP had little or no effectiveness, but there was no description in the documentation of staff behaviors that were consistent with the IIP. This pattern further confirmed that the helping strategy was not uniformly implemented.

Another dilemma emerged regarding the implementation of the New York Model. Clinicians provide YDAs with what they believe to be therapeutic and effective intervention strategies when a youth is in crisis. When the crisis occurs, YDA staff instead appeared to use and list a litany of de-escalation techniques that were part of CPM; but the documentation implied that these CPM strategies were the IIP techniques. In most of the events that lead to or resulted in a physical restraint, the YDA staff documentation indicated that their de-escalation strategies (now attributed to the IIP) were ineffective. The ineffectiveness was corroborated in the Incident Reports that contained sufficient description of the youth's continued escalation of behavior.

The concern about the effectiveness of de-escalation strategies is its presumed inverse relationship to the use of force (Protection from Harm issues): As the effectiveness of de-escalation increases, the likelihood of uses of force and the subsequent risk of harm to youth and staff decreases. Therefore, further investigation of this staff-described ineffectiveness is recommended. If staff are referring to generic CPM strategies rather than specific strategies from the youth's actual IIP, the proposition that the IIP is ineffective is likely false. If staff do not have sufficient skills to implement the actual IIP techniques with fidelity to the model, coaching and/or training needs exist. If the support team believes the actual IIP suggestions are appropriate, but staff fail to implement them because they believe them to be ineffective or contrary to safety and security, then a gap exists in the implementation of the New York Model. The list of concerns could go on, but the point is that gaps existed in ways that Taberg staff tried to implement a consistent and uniform approach to help youth regain emotional regulation and reduce or avoid the use of force by staff.

The PH Monitor's findings support the QAI Report (page 56) where Taberg staff were asked to describe how mental health services are integrated into the daily program, and most staff identified things or events as indicators of mental health service integration. This would be the first part of competent behavioral treatment services, i.e., making sure that the behavioral treatment activities were part of the daily program. However, integration of mental health services into the daily program is more than the counting or describing of mental health related events that occur on the daily program schedule.

Integration would be a function of how the behavioral treatment services or New York Model concepts have influenced how YDA staff conduct the daily routine.

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

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

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

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

COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding. 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. There has been an elimination of facedown or prone restraints in the DOJ facilities. Isolated instances continue to occur as a result of unusual circumstances or concerns about individual staff members (see the QAI Report regarding Restraint Packet 471098).

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's direct observations, youth and staff interviews, and the findings from the Taberg QAI Report support this finding. 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: Taberg has sustained its compliance with this paragraph. The PH Monitor's review, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding. Policy and procedure regarding physical restraint clearly prohibit the use of psychotropic medication solely for restraint purposes. Resident and staff interviews and

direct observations provided no evidence of the use of psychotropic medication solely for restraint purposes.

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

COMPLIANCE

COMMENT: Training remains in compliance. Mr. Rutledge facilitated the use of STARS to review training records for Taberg staff. Those requiring Restraint Monitoring training had completed it. Regarding completion of the CPM training course as a core prerequisite for conducting physical restraints, only two staff members did not qualify. Both were new employees who had not completed the Academy training. There were copies of individual memos sent to each employee from administration advising them that until they have completed the required CPM and first aid/CPR courses, they were not allowed to participate in physical restraints.

B. Use of Force

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

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with youth and staff interviews and the conclusions from the Taberg QAI Report to support this finding. 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 "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 (as is common with most behavioral treatment systems for juvenile correctional facilities) is that the application of its principles and techniques by youth and staff should increase emotional regulation in the face of problems and crises and, thereby, mitigate the accompanying 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. Instead, if this "accompanying practice" were an effective use of New York Model principles, the "amount of force necessary" would be lower.

From the PH Monitor's reviews of Restraint Packets, the following uses of force did not appear to make adequate use of available New York Model concepts; and more force was used than would have been necessary if staff had used the principles of the New York Model: Staff did not use de-escalation techniques (442599, 446801,451401, 451403); de-escalation techniques were used, but they were not the techniques recommended by the support team (434810, 449900); safety expectations for youth and staff behaviors may have seemed mixed (449905); and de-escalation techniques were used inappropriately or ineffectively (445201, 476000, 486504, 449902).

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

COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Restraint Packets, combines with the conclusions from the Taberg QAI Report to support this finding. The policy and procedures exist; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that were consistent with the policy and procedures. Documentation is a challenge in every facility across the country, and the primary concern for Protection from Harm is that there is a system of review that identifies documentation errors and provides corrective action to reduce future occurrences. The approach to documentation in the DOJ facilities is quite extensive and thorough, even though errors and problems occur. Described below are some examples for Taberg administration consideration regarding improvements to staff behavior observation and recording skill development.

Regarding Restraint Packet 449899, the two (2) videos supplied by Taberg staff for the restraints that occurred at 6:38 PM and 6:52 PM did not match the documentation, even though the CSU Restraint Log listed them as the first restraints of this youth on this day. Therefore, the Restraint Packet review was unable to determine whether something in the first restraint(s) contributed to the chain of restraints that lasted the remainder of the evening and led to the referral of the youth to a local psychiatric unit for assessment.

The documentation surrounding the May 14-15, 2013 physical restraints of Youth [redacted] included more than 150 pages of reports, forms, and checklists. The amount of time involved in the production of these documents would be disruptive to the successful or effective operation of the shift and disruptive to staff, especially if the reports have to be completed before the staff member is released.

Regarding Restraint Packet 478299, the video provided to the PH Monitor did not match the documentation.

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

COMPLIANCE

COMMENT: Taberg has sustained compliance with this paragraph. The PH Monitor's review of multiple Restraint Packets combines with staff interviews and the conclusions from the Taberg QAI Report to support this finding. The Therapeutic Intervention Committee (TIC) is the "review by senior management." 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. The TIC will be an important part of the new Graduated Response protocols tied to the new restraint metrics. Home Office should carefully support the TIC to help it reach its full potential within this new system.

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

PARTIAL COMPLIANCE

COMMENT: The PH Monitor's review of multiple Restraint Packets, including the Video Review Forms (VRF), combines with administrative interviews and the conclusions from the Taberg QAI Report to support this finding. 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 enhance the effectiveness of CPM within 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. In the absence of an Assistant Facility Director for Programs, the responsibility for the Facility Administrators Review has been shared between the Facility Director and another YC1. A few VRFs appeared rushed and, in some instances, incomplete.

Regarding Restraint Packet 449905, the fact that there was no audio meant that there was nothing on the video regarding the youth's behaviors before the physical restraint that was consistent with the reasons for physical restraint under Paragraph 40. Therefore, the second issue arising from this Restraint Packet was the nature of verbal behavior. Here again there are probably different perspectives on meaning or classification of verbal behavior based on whether the verbal behavior is directed to a YDA staff member or a support specialist. It likely makes more sense in a treatment facility with abused and traumatized girls with mental health problems for staff to accommodate or tolerate some amount of profane and aggressive verbal behaviors as a form of venting and release of anger. Unless, of course, the agency defines those words as actual acts of violence or aggression and further classifies these words as imminently dangerous behaviors to the

safety of self and others. This is another reason why there should be greater clinician involvement in the Administrative Review of restraints.

Regarding Restraint Packet 449899, the VRF noted nothing of significance, but the youth was referred to a psychiatric unit of the local hospital. From this VRF forward in the review of the multiple restraints for the same youth, the VRF forms contained similar information. To evaluate fully whether (a) the CPM techniques were properly employed, (b) staff interventions were timely, (c) de-escalation techniques were properly employed, and (d) aggravating circumstances could be identified, to name a few, an evaluation of the event beyond the act of restraint is needed. Home Office has maintained that the purpose of the VRF is to review the actions that took place during the restraint and not an entire narrative of the event. Consistent with the recommendation of the Facility Director in Restraint Packet 451403, the PH Monitor also recommends a reconsideration of the amount of video that precedes the physical restraint event would be helpful to the Facility Administration and the TIC in its delineation of issues to include in a facility plan to reduce restraint events.

Regarding Restraint Packet 449902, one YDA staff member wrote in his Incident Report that the youth stated, "So, who's ready for Round 2?" In none of the videos or documentation was there a comment or question that the youth may have derived some type of fulfillment or gratification by all of the attention and physical contact. It would be better if there were a TIC review of these restraint patterns to ensure that Taberg staff are sufficiently trained to help the youth without reinforcing self-defeating behaviors that re-traumatize.

On the video, there appeared to be a lot of talking by staff. The documentation and the video review suggested continued verbal interactions, perhaps arguments, which may have escalated the youth's behavior. Often, these prototypical "power struggles" with staff perpetuate (fail to de-escalate, even escalate) the conflict.

Regarding Restraint Packet 445201, the Physical Restraint Staff Debriefing Report filled out by YC2 Diego indicated that a mental health referral was needed, and the report stated, "Youth in need of mental health counseling to acquire skills to help her deal with her anger issues/coping skills." This was another instance where security staff, perhaps believing that they were sufficiently trained and equipped with the skills required by the New York Model, found what they assumed to be an ineffective treatment intervention as evidenced by the youth's continued angry and violent outbursts.

The review of the video often provides examples of what other staff and youth were doing as the physical restraint developed and was resolved. Sometimes these behaviors are not directly related to the physical restraint, as in this case, but they are noteworthy. Regarding Restraint Packet 451403 and youth/staff boundaries, the video showed one youth with her foot on a staff member's leg. The staff member removed her foot from his leg, but it still remained on his foot. This is questionable touching and represents a staff misconduct "red flag" incident. Documented Instruction was justified.

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: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of STARS data and a Bureau of Training staff interview support this finding. The training on the policies and procedures has 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 all direct care staff received the required training on CPM. The records also showed that staff members who required retraining for any number of reasons 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 knew when re-training events would occur and in what activities they were permitted to participate.

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of the Restraint Log in CSU combines with youth and staff interviews and the conclusions from the Taberg QAI Report to support this finding. 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, where Code Yellow = security emergency, Code Blue = medical, Code Gray = mental health issues, Code Green = Fire/Safety Emergency; and Code White = restraint in progress.

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets and the Restraint Log from CSU, combines with the conclusions from the Taberg QAI Report to support this finding. The policy and procedures exist (PPM 3246.02); the training on the policies and procedures has occurred; and staff reports were consistent with the policy and procedures. The PH Monitor verified the existence of the response team chart in the CSU booth and the log entry of response descriptions in the CSU logbook.

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

COMPLIANCE

COMMENT: Home Office has addressed the requirement for an emergency plan through the development of the Crisis Response and Radio Communications Policy (PPM 3246.02). The policy complies with the intent of this paragraph. Further, Local Practice, which interprets the policy for implementation at Taberg, is expressed in the Taberg Residential Center for Girls Local Operating Practice (3246.02). The Local Policy complies with the intent of the paragraph.

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of training records combines with staff interviews and the conclusions from the Taberg QAI Report to support this finding. 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) and the new Justice Center, officially implemented as of June 30, 2013. The Monitors appreciate the information provided by Home Office on the development and responsibilities of the Justice Center, but questions remain about its relationship to certain Settlement Agreement paragraphs. The Monitors recommended that any implications for monitoring be resolved first by the Parties (Home Office and DOJ). As such, the Parties have agreed to the following:

> In light of the fact that some of the responsibilities described in Agreement portion Section III.A, paragraph 44 have been reassigned from facility control to centralized

state control (SIU and/or the Justice Center), the parties agree that Paragraph 77d termination shall not be conditioned on compliance with those subsections. Specifically, the subsections that are outside of facility control include: 44b, first sentence only, and 44d, e and h. This understanding in no way removes the requirements of paragraphs 44b (first sentence), or 44d, e or h from the Agreement, and substantial compliance with these paragraphs is still required for Termination pursuant to paragraph 77a and 77b.

The findings in this section take into account the Parties agreement regarding Paragraph 44.

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: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of restraint documents including reporting actions, along with interviews with staff and youth, yielded similar results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of an inappropriate use of force or suspected abuse.

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.

First Sentence: The Parties agree that this part of Paragraph 44b is outside the control of Taberg staff and is not included in the compliance findings for this facility.

Second through Fourth Sentences: COMPLIANCE

COMMENT: In those instances where there were allegations, the Facility Director made the initial determination in conjunction with her supervisor (the Facilities Manager) and with OCFS regional staff supervised by another arm of OCFS that oversees the creation

of safety plans. No problems or concerns were noted regarding a prompt determination or an appropriate level of contact.

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The PH Monitor's review of data, including the Post Restraint Examination (PRE) procedures and documentation, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding. The policy and procedures exist, and staff and resident interviews were consistent with the policy and procedures. The key issue here was the safeguarding of a youth's opportunity for a candid conversation during a post-restraint examination with a trusted health care provider, so that she can then more easily provide confidential information regarding the use of force incident, any allegations of excessive use of force, and any injury complaints. Every youth interviewee who had been previously restrained at Taberg confirmed an opportunity to talk privately to a nurse during a post-restraint examination.

The QAI Report noted on page 76 a documentation discrepancy in Restraint Packet 471098. An Incident Report stated that the PRE did not contain an allegation to the nurse by the youth of staff abuse, yet the RIR claimed that the youth stated that she made an allegation to the nurse during the PRE. In a follow-up discussion with the nurse, she clarified for the PH Monitor that the youth identified areas where she was in pain, which the nurse found to be consistent with the physical restraint, but at no time did the youth allege that staff did something excessive to hurt her. The confusion seemed to be that the youth reported on the pain, which was interpreted as the youth having reported on the staff. The clinical notes supported the nurse's perspective

The health clinic remains a key part of Protection from Harm safeguards. Clinic staff members continue to be knowledgeable about reporting functions related to abuse allegations, and there was no evidence of any hesitancy to report on the part of a Qualified Health Care Professionals for fear of retaliation or reprisal.

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.*

The Parties agree that Paragraph 44d is outside the control of Taberg staff and is not included in the compliance findings for this facility.

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

The Parties agree that Paragraph 44e is outside the control of Taberg staff and is not included in the compliance findings for this facility.

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 level of staff supervision at Taberg was not yet consistent with generally accepted professional practices based on concerns about reoccurring problems with the distribution of staff and with consistent approaches to confront and resolve minor problems. Two examples from the Restraint Packet reviews were illustrative. First, regarding Restraint Packet 486499, the video started in the unit dayroom where four (4) staff members were at the desk, three (3) sitting. One staff member appeared to be engaging two girls who were also at the desk. Another staff member appeared to be doing paperwork and two (2) other staff members appeared to be talking to one another. This was a generally unacceptable distribution of staff for direct supervision. Second, and as discussed above, the Facility Director's review of Restraint Packet 451403 prompted concerns about the adequacy of staff supervision regarding the role "horseplay" and the lack of an appropriate staff response as primary contributors to a physical restraint.

This is a correctable situation, and the appointment of an Assistant Facility Director for Programs should provide the oversight for a facility-wide stabilization of staff supervision such that these issues are resolved effectively. Additionally, Home Office has

improved the Restraint Monitor training curriculum to further strengthen staff supervision and youth safety during restraint events.

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.

The Parties agree that Paragraph 44h is outside the control of Taberg staff and is not included in the compliance findings for this facility.

III. MENTAL HEALTH MONITORING

This site visit at Taberg revealed continued progress in implementing the New York Model. Regarding the ten mental health paragraphs of the Settlement Agreement, OCFS completed two policies, Juvenile Justice Information System (JJIS) instructions, and the substance abuse manual. The MH Monitor is focusing on staff demonstration of consistent New York Model practices to determine compliance. The biggest obstacles to New York Model implementation at Taberg are a shortage of clinicians and the absence of an Assistant Director of Treatment since 2012 which result in a lack of leadership for coaching (particularly guiding YDAs' encouragement of residents' use of self-calming and other skills), and, as the QAI Review noted, limited staff supervision to encourage improved quality of support plans.

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 at Taberg examined residents' records for integrated assessments, psychiatric evaluations, support plans, diagnoses, psychiatric contact notes, medication, family outreach, suicide response,

substance abuse services and release planning, staff and residents were interviewed, and support teams, Mental Health Rounds, groups and change of shift meetings were observed, which showed progress in these practices.

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

The New York Model and BBHS procedures regarding Mental Health Rounds, support teams, and the coaching role of mental health staff, comply with the requirements of 46b.

Mental health staff at Taberg were observed complying with 46b. As discussed below, having too few clinicians will make it difficult for Taberg to maintain compliance with this paragraph.

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

COMPLIANCE

The New York Model and BBHS procedures regarding Mental Health Rounds, and support teams comply with the requirements of 46c.

Through support teams and Mental Health Rounds, Taberg staff are complying with 46c on an individual basis. The Taberg Integrated Assessment, IIP, Support Plan, and contact notes by the psychiatrists, clinicians, YCs and CMSO were all accessible 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.

The MH Monitor observed that Taberg staff have begun to use pre-shift briefings and the TIC to assess facility-wide effectiveness of interventions for all residents in compliance with 46c. Disseminating findings from QAI reviews and monthly restraint data in unit meetings and the TIC are also ways to enhance the effectiveness of interventions facility-wide, and will continue to be monitored.

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.

COMPLIANCE

OCFS released the Facility Admission and Orientation policy (PPM 3402.00 Limited Secure and Non-Secure Facilities Admission and Orientation and PPM 3402.01 Secure Facilities Admission and Orientation with the Admission Checklist, Orientation Checklist

and Facility Classification forms) and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") to be consistent with the New York Model and comply with 46d.

Taberg staff provide orientation to new residents in compliance with 46d.

The QAI Review at Taberg found that all the youth were oriented to the program upon their admission, although documentation on the new Orientation Checklist (OCFS-4911-2) could be improved.

On Site Observations Regarding Paragraph 46a-d (9/13)

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 residents' complex needs. All the girls at Taberg have long histories of trauma and troubled behavior, and staff dedication to teaching residents emotional regulation was apparent.

The MH Monitor observed Mental Health Rounds with one Taberg unit. All the girls on the unit were reviewed, the discussions were productive, everyone made contributions, the psychiatrist actively participated, and the nurse managed the meetings. The discussion focused on strengthening support for residents, status of planning for discharge, and work with families. The psychiatrist said little about diagnosis or medications. Two support teams were reviewed. Staff were pleased that one girl was proud that she did not react to another girl's provocation and said: "I'm learning how to control myself;" the school was reminded to schedule a CSE for her since she will be released in November. Another girl's approval for RTF was discussed—she had no self-injuries in eight days. There was a discussion that staff do not want several girls to deteriorate before their discharge. For another girl the group decided to propose that a goal about learning social skills be added to her support plan. The nurse notified them of the results of a urology study—all staff should be informed that the resident is unable to control her urine normally. Participants in Mental Health Rounds felt they had made a lot of progress since the last site visit. They want a facility-wide training on how trauma affects residents. They were discouraged about lack of YDA involvement in Mental Health Rounds, which was a concern at the last site visit. Their goal is to get more information from Mental Health Rounds out to YDAs. On the other hand, they are concerned about the confidentiality of the information. It is imperative that facility scheduling ensures YDA involvement from both morning and evening shifts every week for Mental Health Rounds and support team meetings.

The MH Monitor observed excellent DBT groups (one on each unit) and a Sanctuary group at Taberg, and the residents were actively involved—all three were examples of effective New York Model practices. One DBT group skillfully led by a YC used an exercise and the girls could see that listening and talking are both essential for communication. The participants ranged in age from 11-17, and having a discussion that included residents with such a wide range of maturity levels and cognitive abilities is a challenge. Consistently having the group at 4 PM has worked well for residents and the evening shift YDAs are

involved—YDAs and YCs want more training on group counseling. Taberg tends to use classroom seating for groups because staff consider it easier to manage, but sitting in a circle might make residents feel part of a safe community. One DBT group was led by a clinician who did a great job supporting a girl to play a leadership role. Another DBT group was co-led by a YDA and clinician who started with a mindfulness game involving everyone that encouraged "learning to think hard, noticing, and not giving up." They continued with an emotion regulation activity, which led to the YDA picking up on a girl's experience by asking her about her thought process, while he wrote on the board "the prompting event—interpretations—emotion—action—consequences." She talked about when she "gets to 5" (out of 10), how she "brings herself down." In the debrief of this group, the co-leaders were excited about what this girl said and how it could be used to benefit her and other residents. They have many ideas about how to get more girls talking and "learning that their interpretations about an event are not fact, they can decide how they choose to react to a prompting event." They worked hard to draw the nonverbal girls out, and the YDA commented that he uses individual mentoring time to keep group learning continuing, especially with the introverted residents. The clinician and YDA were proud of their collaboration and their strong unit team.

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, clinicians, and an 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. Nevertheless, they feel they coach and model New York Model practice every opportunity they have. They view Mental Health Rounds and support teams as primary times to coach staff [but few YDAs are involved in either of those meetings]. Given their limited time, they do not meet as a coaching team, so giving each other support and expanding their coaching repertoires is not built into their routine. The Taberg coaching team—especially with the addition of new staff—requires more guidance from BBHS.

Taberg has too few clinicians. If one of the clinicians becomes the Assistant Director of Treatment, Taberg will be missing two clinicians. An insufficient number of clinicians will make it difficult for Taberg to consistently demonstrate compliance with Paragraph 46: despite their quality clinical work, they will not be able to provide individual therapy as often as necessary, tailor group therapy to meet residents' needs, do family therapy by telephone or in person as often as necessary, manage suicidal residents and contribute in support teams, or coach staff effectively and complete paperwork. In the month of August, one clinician saw 19 girls, four (4) individually and all of them for groups. Most were in 5-6 groups with him during the month. He saw them individually four or five times in the month. The clinician who left saw five residents individually and 12 in groups in her last month. Another clinician saw five residents individually (between 2-5 times) and 12 in groups that month. The two new clinicians saw four residents and seven residents each individually, several more than five times. Family sessions were not noted for the majority of girls.

By comparison, in August 2013, Columbia had 367 care days and has an Assistant Director for Treatment and two other clinicians, a psychiatrist who works 7.5 hours per week, an NPP who works 20 hours/week in psychiatry, and two (2) YCs. In August 2013, Taberg had 627 care days and has four clinicians, one psychiatrist who works 12 hours/week and another psychiatrist who works 9-10 hours/week, and two (2) YCs. The allocated number of OCFS and OMH clinicians plus an Assistant Director for Treatment may not be sufficient for the size and complexity of the Taberg population, and for two years Taberg has never had all those positions filled. During that time, responsibilities for substance abuse individual and group treatment, special watch evaluations, staff coaching and JJIS documentation have substantially increased. The additional requirement that all clinicians work every weekend makes recruitment much more difficult—it is hoped OCFS will reconsider and allow the Assistant Direct for Treatment to work every Saturday with the other clinicians rotating one Sunday per month each at Taberg.

An example of the need for coaching a stronger shared response by clinicians and YDAs is evidenced by [redacted] self-destructive behaviors and multiple restraints one evening. Thorough clinical work at Taberg, and clear documentation of it, is exemplified in [redacted] record. [redacted] was [redacted] years old when she was admitted to the Taberg MHU in 8/12 for an assault. She was discharged more than 10 months later (6/13) to an [redacted] In 4/13, the psychiatrist did an updated evaluation summarizing [redacted] treatment since she was last evaluated in 10/12: "[redacted] has had only a single episode of dysregulated/aggressive behavior since her transfer to Taberg over nine months ago [in 11/12] when she climbed over the serving counter in the dining area and then required restraint in the kitchen. She was arrested due to some assaultive behavior during the restraint (no serious injuries). There were no clear precipitants to this behavior and no signs/symptoms of psychosis or major mood symptoms before or after this episode. [redacted] has otherwise remained very stable, both behaviorally and emotionally and has been without significant signs or symptoms of psychiatric problems. She has refused her medications only 3-4 times in 9 months—each time without articulating a specific reason." Her goal in her support plans was to move to an RTF which was described as involving "identifying triggers for anger and aggressive behavior and verbalizing how insecurity is connected to anger control problems;" she was to work on emotional regulation in individual therapy twice weekly with her clinician, with other staff encouraging her to use her safety plan and skills. On 4/28/13, her YC had individual counseling with [redacted] helping her prepare her portfolio and questions about the RTF program for her RTF visit. On 5/2/13, her therapist described [redacted] day trip with him, a YDA, a nurse, her mother, and her CMSO to the RTF. She did well in the interview and learned she was next on the list to be admitted. On 5/8/13 the psychiatrist reported that her RTF visit went well and she hopes for admission "any day. She is very upbeat about this and 'can't wait.'" She was stable, fully compliant with treatment and her diagnosis of Mood Disorder and medication remained unchanged. On 5/12/13, her YC said in an individual counseling note that [redacted] was very anxious about the unknown date of her discharge to RTF: "Discussed strategies in how to combat the anxious feelings she is having. She believes talking to staff is the best route to assist her. I urged her to not bottle things up inside and utilize staff when her emotions get the best of her." On 5/13/13, her therapist said in an individual therapy note that [redacted] frustration that the RTF had not given her an admission date was causing her "significant sadness/irritability. Clinician reviewed

what had been stated by the RTF social worker that she has been accepted and is next on the list. Processed what is in her control and what is out of her control and of the facility's control. She was encouraged to maintain proper behavior and DBT skills [were] discussed. Throughout the session time she was very reserved. Clinician placed a phone call to CMSO and after clinician's discussion, [redacted] had time to talk." On 5/14/13, her therapist noted that he was called at home at 8 PM by the AOD that [redacted] had been involved in multiple restraints and remained unable to control her behavior. "Clinician came to the facility, arrived about 9 PM. [redacted] was in the Comfort Room with multiple staff. She was observed at times biting at her arms, banging her head on the wall and struggling with staff trying to prevent her from harming herself. Attempts by clinician and others to engage her in discussion failed as she refused to take any suggestions related to calming techniques. Staff reported she had ingested an item, tied a scarf around her neck in an attempt to choke herself, been assaultive towards staff, and refused her nightly medication. Situation continued and decision reached to send [redacted] to [redacted] Hospital for evaluation after 11 PM [at which point] she had calmed significantly." On 5/15/13, after she returned from the hospital, her therapist did a Suicide Watch evaluation. "Possibly continues to be at risk for impulsivity/violence as return to baseline has not been achieved at this time. She has made some progress re-engaging with the program/unit routine since returning from the hospital about 11 AM this day. A longer period of her engagement in the routine of the facility and of her maintaining/accepting responsibility for self-safety and care of self is indicated. Therefore Suicide Watch (one-to-one) supervision will be continued. She engaged in a discussion of skills such as using positive self-talk and thinking of home as deterrents against falling victim to stress. She completed the ISO 30 with result of 'LOW' risk. She will be re-evaluated on the next day." On 5/15/13, Mental Health Rounds notes reflected a discussion of [redacted] her frustration with the RTF delay, and her YC reaching out to her mother for more frequent contact. On 5/15/13 the psychiatrist reported that she could not explain why she "lost control," noting in was reminiscent of the similar incident with no precipitant in November. On 5/16/13, her therapist did another Suicide Watch evaluation, commenting that she "continues to make progress re-engaging in the program/unit routine. Consult with staff (YC, AOD, Medical, YDA Education) indicate a continued concern for the safety of peers and staff. Her personal safety has been maintained and she has noted she has no intent or plan of causing harm to herself. Status of Suicide Watch (SW) is discontinued and [redacted] is now placed on Personal Safety Watch (PSW) status. She will be re-evaluated on the next day. Skills Discussed: Radical Acceptance/Patience." On 5/17/13, her therapist did a Personal Safety Watch evaluation and returned her to regular program. On 5/21/13, her YC said in an individual counseling note that "she understands the importance of patience. We discussed communicating with a trusted staff her feelings to stay emotionally regulated and this will help her make good decisions in daily program. When she gets to the point when she cannot handle it herself, [redacted] commits to 'lean on' staff and get the support she needs." On 5/22/13, the psychiatrist noted, "Staff report that [redacted] has been gradually returning to her baseline prior to last week's incident and has been off of all precautions for last several days. She has apologized to staff (without prompting), has been fully compliant with medications and programming, and is back on track."

While the precipitant of [redacted] self-harming behavior and repeated restraints on 5/14/13 appears to be a mystery to her and her staff, the teamwork among her YC,

therapist and psychiatrist and their frequent support for her before and after the incident were exemplary. With the benefit of hindsight, making the evening shift AOD and YDAs aware of [redacted] increasing anxiety on 5/12 and despondency on 5/13 and also suggesting explicit interventions might have made a difference (but probably did not seem warranted given her months of improved self-regulation). Possibly the result would have been staff less taken by surprise by her rapid escalation and able to provide her with immediate one-on-one support that could have avoided self-harming and restraint. Especially in the light of staff concerns discussed at Mental Health Rounds and support teams during this site visit regarding ensuring that residents do not continue to deteriorate before discharge, heightened coordination of the efforts of clinicians, YCs and YDAs for girls with increased anxiety as their release approaches is a high priority. This harmonious use of the New York Model by all staff requires clinicians with the time to observe that a girl's skills may be taxed by stress and to coach others about how to give her extra support.

The Taberg DAS remains the same rule and compliance oriented checklist as it was at the previous two site visits, and the MH Monitor again encourages Taberg to consider adopting the Columbia skill-based DAS. Taberg staff are learning how to use the DAS as a shaping tool for residents. It continues to be difficult for some staff when a resident does not use her skills at one point in the day but gets rewarded at the end of the day for recovering.

The MH Monitor reviewed the DAS for a 16-year old resident (at Taberg since May, 2013) for several days. On 9/21 she earned an A (all but two (2) of the 25 achievements—she was scored as not showing effort 6-10 PM and 2-6 PM although no notes indicate why. On 9/22 she earned a B (all but six (6) of the 25 achievements—during 6-10 PM she was scored as not showing effort, not following program, not accepting circumstances and not following program rules and 2-6 PM not following program rules at dinner and not using skills to avoid problems). On 9/23 she earned a C (for 9 of the 25 achievements—during 6-10 PM she was scored as not showing effort and not using skills to avoid problems (language); during 10 PM-6 AM she was scored as not showing effort (not explained how this happened while sleeping); during 6-10 AM she was scored as not showing effort, not following program (Code Yellow called), not accepting circumstances, not using skills to avoid problems (language), and not following program rules (walking out of class); during 10 AM-2 PM she was scored as not showing effort, not following program, not using skills to avoid problems and not following program rules (language); during 2-6PM she was scored as not showing effort, not using skills to avoid problems and not following program rules (left line movement)). On 9/24 she earned a B (all but five (5) of the 25 achievements—during 6-10 PM she was scored as not showing effort and not using skills to avoid problems (language); during 6-10 AM, 10 AM-2 PM, and 2-6 PM she was scored as not showing effort). It should be noted that using unacceptable language was scored by some staff as not using skills to avoid problems and by others as not following program rules. It is unclear from the DAS form what the difference is between not following program rules and not following program. It is unknown how a resident could earn or not earn an achievement while sleeping (and if she was not sleeping during 10 PM-6 AM that should be explained on her DAS). The MH Monitor observed this resident show exemplary leadership in groups and caring behavior toward a cognitively-limited resident, so staff feedback to her on a day when she received no achievements for showing effort might have

warranted a note by the YC or clinician (particularly since she was diagnosed with Mood Disorder, Impulsivity and ADHD). During the site visit, this articulate resident sought and had a productive discussion with the BBHS Director of Treatment Services about the problems of inconsistent DAS scoring by staff, demonstrating her skill at being able to present her frustration thoughtfully and convincingly.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Taberg records; support plans indicated the IIP has been reviewed each month. In July 2013, OCFS revised the IIP form to make it clearer. It is a simpler form, focusing on what staff will do to calm the youth, as well as the prohibited and approved physical interventions for the youth. The BBHS Facility Clinical Procedures described the process of arriving at the IIP: "The clinician will work with the youth to determine what de-escalation techniques used by staff will be most helpful to the youth given the possibility of difficulty with emotion regulation." The MH Monitor observed modifications in girls' IIPs being discussed at Taberg.

The MH Monitor observed a pre-shift briefing in the front hallway with 16 staff, including the YC who led, three (3) clinicians, two (2) teachers, a nurse, four (4) morning shift YDAs and four (4) evening shift YDAs. There was a brief report on girls having difficulty, including the one restraint of the day, a summary from the school, and a reminder that a girl is leaving. A teacher wrote a positive report on a resident for using Radical Acceptance. A clinician described the girl in a group who said when she "got to 5" she is able to calm down. Three other girls were also commended, and the YC urged everyone, "Make sure to reinforce these positives on your unit." They completed the briefing with encouragement from the YC to get all the residents outside in the good weather. Then the YC moved to his unit and convened a shift change briefing with two (2) morning shift YDAs, two (2) evening shift YDAs and two (2) clinicians where they quickly reviewed each resident on the unit. The YC sought their advice about whether a resident who had been doing well for two (2) days should come off arms length supervision; each staff person contributed, and he said he would check in with the AOD before telling the resident. These meetings were commendable for their collaboration and rapid exchange of helpful, readily-usable information.

The PH Monitor and MH Monitor observed a meeting of the Taberg TIC to discuss the latest data from the Graduated Response Protocol, provided to them by Home Office staff that initiated their monthly facility TIC review of restraint data. The Taberg Director plans to discuss monthly restraint data with YDAs and YCs at unit meetings. One YC said the unit is a good place to discuss what can be done if a particular time of day—for example, shower time—is rough for girls, then figure out how to manage to make it smoother for residents. The AOD said it is important to encourage staff to provide daily help to each resident to have a better day or better evening. The Director pointed out that she meets with the AODs and Assistant Directors to discuss individual restraints daily, but this monthly restraint review at unit meetings would be an opportunity to help staff think about their roles differently. One of the goals of these discussions should be helping all staff understand how what they do supports residents in calming themselves before they have to be de-escalated, and thus avoiding restraints. Although not discussed during the site visit, unit meetings would also be a place to present highlights of QAI findings as

another way to regularly assess facility-wide effectiveness of interventions; because QAI reports are long, it is doubtful most facility staff read them, but it would be beneficial for staff to hear their unit team members and themselves commended by QAI for good practice and also to develop unified approaches to improvements recommended by QAI. The MH Monitor recommends that QAI prepare a single page summary of highlights of good practice and recommended improvements after each QAI review to encourage consistent discussion of their findings at unit meetings.

During the staff interviews in the QAI Review at Taberg, few respondents were able to adequately provide a definition or description of the New York Model and only a third correlated it to a trauma- informed approach for working with OCFS youth. In contrast, all respondents were familiar with the Daily Achievement System (DAS) and its role in assessing a youth's behavior on a daily basis and awarding incentives for positive behavior. Most reported the DAS to be inconsistently applied. One respondent specifically asked for training in the NY Model and the DAS, stating that while he/she attended training in the past, it would be helpful to repeat the training now that the facility has implemented the NY Model and the course content could be applied within a meaningful context.

The QAI Review described observation of Mental Health Rounds on one unit involving only the psychiatrist, clinician and a medical representative. Four of the 11 girls on the unit who were having particular problems were discussed: "Each case review focused on behavioral and family concerns, youth goals, release plans/options, including ways to help youth that were struggling. Although the discussion was in depth, involvement from other areas of program was lacking which could have revealed added perspectives and enhanced strategies for working with the youths. It is unclear on how this information will get disseminated since a note taker was not observed during this meeting."

The QAI Review described observation of a DBT group, indicating it is offered weekly. Four youth, one YDA and two clinicians participated. The topic was Distress Tolerance and focused on crisis survival strategies. "The group discussion was well facilitated and [staff] were able to constructively engage the youth. The youth appeared to feel safe sharing their opinions with each other. Staff did a nice job of patiently redirecting the conversation and maintaining a positive tone throughout. All participants were given positive reinforcement for their hard work and input by the facilitators."

The QAI Review found that IIPs were detailed, helpful, complete, and updated. However, only a third of staff interviewed indicated that they reviewed IIPs at shift change or after crises.

The QAI Review described observation of a pre-shift briefing in which staff were reminded to be proactive, two youth on SW and one returning from jail were discussed, and two Red Flag meetings were summarized.

FUTURE MONITORING

The MH Monitor will review the adequacy of Taberg's clinical staffing and coaching capacity.

The MH Monitor will observe the facility's use of information—particularly using monthly restraint data and the QAI--to regularly assess the effectiveness of interventions for all residents.

The MH Monitor will observe coaching and the continued implementation of successful Mental Health Rounds 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.

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 and has been followed by staff.

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. After a Suicide Watch, mental health staff meet with the resident to help her develop coping skills to avoid future self-harming thoughts or behaviors. When residents' continue to injure themselves, staff struggle together to understand what they can do to prevent the behavior.

On Site Observations Regarding Paragraph 47a-c (9/13)

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.

Taberg had 106 special supervisions between 3/18-9/20/13. Arms Length Supervision (ALS) ranged from 4-12 per month during full months in that six-month period. Suicide Watch (SW) ranged from 3-10 per month during full months in that six-month period. Personal Safety Watch (PSW) was rare. While one resident accounted for many days of ALS in the early part of the six month period, four residents accounted for seven or more SWs each at the end of the six month period. ALS and SW were typically 1-2 days in length, but five residents had suicide watches as long as 4-8 days. In the first 20 days of September 2013, nine different residents accounted for the 19 special supervisions. Completing several mental health assessments for suicide a week, and then re-evaluating is a major time commitment for clinical staff, especially as understaffed as Taberg was. Suicide Watch documentation by the clinicians in the Taberg records was thorough.

Although one reviewed record had a documentation problem, the QAI Review noted "very good documentation of the clinician monitoring the youth on suicide watch." As in the January, 2013 QAI report, the vacancies in both the Assistant Director for Treatment and the Assistant Director for Program was described as reducing the coaching of clinical staff on documentation and coaching staff on IIP reviews. The QAI Review concluded that the lack of de-escalation or not using the de-escalation in the resident's IIP were indications of the need for further coaching of staff.

FUTURE MONITORING

The MH Monitor will observe coaching of staff on teaching youth to self-calm, de-escalation, and chain analysis to prevent mental health crises of girls at Taberg.

The MH Monitor will discuss with clinicians the unusually high rate of special watches at Taberg, what factors might be contributing, and what additional interventions could be effective.

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

The recently-released BBHS Facility Clinical Procedures summarized the Integrated Assessment: "While several different support team members enter information into this shared assessment, the clinician will review this multidisciplinary report for accuracy and completeness, ensuring that the information presented provides for a solid conceptualization of the youth and their family strengths and support needs" which complies with 48a.

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.

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.

COMPLIANCE

The Integrated Assessment form complies with 48c. Taberg staff are completing the Integrated Assessment for every resident.

Efficacy of interventions are discussed in Mental Health Rounds and psychiatric contact notes, and the psychiatrists bring research findings or treatment information to the attention of staff. This is also a role for the Assistant Director for Treatment and other clinicians.

Improvements needed are that every Integrated Assessment should include:

(a) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior (unless there has not been trauma),

(b) evidence of learning disabilities and how they appear to be affecting the resident's behavior (unless there are no learning problems),

(c) history of substance use and how it may be related to behavior and trauma (unless there has been no history of substance abuse).

If a resident's Integrated Assessment does not explain how trauma, learning disabilities, and substance abuse affect her behavior, her support plan goals and interventions will be incomplete. Thorough Integrated Assessments take time, and an insufficient number of clinicians will make it difficult for Taberg to consistently demonstrate compliance with Paragraph 48.

Four of five records scored in the QAI Review of Taberg did not meet standards because the Integrated Assessments were not completed in a timely way and/or were incomplete. In some Integrated assessments reviewed by QAI, background information—including trauma and family history—was not presented in sufficient detail; substance abuse needs were not included in specialized treatment needs in Integrated Assessments.

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.

COMPLIANCE

Taberg clinical contact notes, particularly the Psychiatric Contact Notes, discuss residents' symptoms and diagnoses, in compliance with 48d.

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.

In the QAI Review, in one reviewed record the Taberg psychiatrist had not completed a psychiatric evaluation recommended by reception to rule out a diagnosis.

On Site Observations Regarding Paragraph 48a-e (9/13)

BBHS policy requires that "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 support plan (Page 8). The BBHS Facility Clinical Procedures expand on the policy: the clinician updates the youth's current diagnosis in the support plan, but "only if changes are agreed upon between the clinician and psychiatrist. The assistant facility director for treatment should be consulted when the facility clinician and psychiatrist are unable to reach an agreement about the youth's diagnosis. The regional social work supervisor and chief of treatment services should also be consulted in instances where the primary treatment team is unable to reach consensus surrounding the youth's diagnosis." The BBHS Facility Clinical Procedures define a process that ensures that all support team members "are providing interventions to assist the youth and family in effectively managing or reducing symptoms associated with the current diagnosis." When a diagnosis is given at reception or secure facilities, in the facility diagnostic evaluation, the integrated assessment, and the support plan, the uniform working diagnosis screen in JJIS is automatically updated to keep track of the diagnostic history of the youth.

This system for updating diagnoses may be undermined by two discrepancies the MH Monitor has observed in the DOJ facilities: (1) it appears that in each psychiatric contact note, the psychiatrist renders the diagnosis of the youth at that session—these notes can be written 1-4 times monthly and a range of diagnoses may be given; if the psychiatrist and clinician do not discuss current diagnosis immediately before the support team, the support plan may carry over the diagnosis from the previous support team without regard to changing interpretation of symptoms by the psychiatrist; and (2) the diagnosis and medication list prepared by facilities for monitoring visits are different from the diagnosis in the most recent support plan and/or most recent psychiatric contact note (medications are also often not up-to-date on those lists).

The August, 2013 version of the Scope of Work of OCFS Psychiatrists was reviewed by the MH Monitor; it is being finalized by the newly-appointed consulting Chief

Psychiatrists. It briefly lists the ten duties of OCFS psychiatrists, including medication management, attending weekly Mental Health Rounds, attending support teams as directed by the facility administrator, restrictions on number of medications, required laboratory studies, informed consent, and psychiatric emergency evaluations. It does not provide guidance for psychiatrists about their role consistent with the New York Model requirement of integrated care among all staff in the facility and community. It does not describe the role of the psychiatrist in reaching a uniform consensus diagnosis with others on the youth's support team, nor how the psychiatrist's changing diagnostic interpretation of symptoms will benefit the work of other team members with the youth. 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. A Home Office next step is for the practice guidelines in the BBHS Facility Clinical Procedures to be re-framed by a New York Model-experienced psychiatrist for psychiatrists, with particular attention to diagnosis, helping staff make use of information about symptoms and medication, and the role of the psychiatrist in Mental Health Rounds and support teams.

The MH Monitor examined the diagnoses of all 43 youth prescribed psychiatric medication by four psychiatrists and two NPPs at Columbia, Finger Lakes, and Taberg in July 2013. This analysis revealed considerable range among psychiatrists about diagnosis, with the most common diagnoses across the three facilities being ADHD, mood disorders, insomnia, depression, and anxiety in July 2013:

ADHD 23% of youth prescribed medication (10)
- Columbia 25% (2)
- Finger Lakes 35% (7)
- Taberg 7% (1)

MOOD 21% of youth prescribed medication (9)
(including Mood Disorder and Mood Dysregulation)
- Columbia
- Finger Lakes 10% (2)
- Taberg 47% (7)

INSOMNIA 16% of youth prescribed medication (7)
- Columbia 25% (2)
- Finger Lakes
- Taberg 33% (5)

DEPRESSION 9% of youth prescribed medication (4)
(including Depression, Major Depressive Disorder, and Dysthymic Disorder)
- Columbia 39% (3)
- Finger Lakes 5% (1)
- Taberg

ANXIETY 9% of youth prescribed medication (4)
(including Anxiety Disorder and Generalized Anxiety Disorder)
- Columbia 13% (1)
- Finger Lakes 5% (1)
- Taberg 13% (2)

In July 2013, more youth were diagnosed with depression at Columbia (39%) and Mood Disorder at Taberg (47%) while 35% of youth at Finger Lakes and 25% of youth at Columbia were diagnosed with ADHD. There was a large reduction of diagnosing depression (27% in January, 2013 to 9% in July, 2013), anxiety (23% in January, 2013 to 9% in July, 2013), and insomnia (32% in January, 2013 to 16% in July, 2013) across the three facilities. Diagnosis of ADHD was the same between January and July, 2013 (23% of youth) and similar for Mood Disorders (27% in January, 2013 and 21% in July, 2013).

Although divergent diagnoses among the individual youth in the three 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 clinicians 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.

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.

An example of the importance of staff understanding of a resident's evolving diagnostic formulation and what it means for their role in assisting her is [redacted] whose treatment at Taberg appeared superficial. [redacted] is a 13-year old who had been at Taberg almost three months for [redacted] and aggression [redacted]. She was raised by her maternal grandmother; her mother, mother's boyfriend, [redacted] also live in the home. The reception record described her as needy, attention- seeking, sexually abused, hyperactive, depressed and aggressive with an FS IQ 87, poor working memory and comprehension, but average reading and math skills. Although neurological testing was normal, she is self-conscious about her appearance as a result of skull surgery as an infant. She was psychiatrically hospitalized 12 times and was asked to leave a residential center that characterized her as "one of the most violent children they have had." Records from her hospitalizations and residential treatment would have been informative but were not in her Taberg file. The diagnosis on her support plan was Bipolar I Disorder, PTSD, and Personality Disorder. Her goal in her support plan was to live with grandmother. In the three weeks prior to the site visit, [redacted] had three individual sessions with her YC, five individual sessions with her clinician on triggers and reactivity (in addition to three suicide evaluations), one Sanctuary, one DBT and TRIAD groups, and three psychiatric medication reviews for Abilify and Celexa. Her most recent psychiatric contact note gave a diagnosis of Conduct Disorder, Cluster B traits, but on the current population list her diagnosis was PTSD and her medication was Celexa. Discussion in Mental Health Rounds focused on her racist comments, which antagonized other residents (including a group attack on her) and her frequent restraints. One staff observed her pattern of arguing with peers, making antisocial statements, and getting placed on

ALS/SW: "she has unsafe behavior to get one-on-one attention from staff." Her mother and grandmother were reported to say that her behavior was the result of being "totally indulged," and staff appeared to be viewing [redacted] in this way rather than recognizing the effects of unresolved trauma and likely processing problems as requiring more intensive intervention. The lack of a consensus diagnosis and clear targeted symptoms may contribute to staff lacking a sophisticated, coordinated approach to her trauma-related behavior.

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 continue to discuss consistency in diagnostic practices with psychiatrists and other clinicians and ongoing efforts to arrive at consistent diagnoses.

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.

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 to state "the target symptoms intended to be treated by each medication." The MH Monitor observed the Taberg psychiatrist explaining the rationale for prescribing particular medications to treat a resident's symptoms. One Taberg psychiatrist typically does not check any symptoms on the symptom checklist on the psychiatric contact notes. Given the QAI findings below, the MH Monitor recommends that the psychiatric contact note be revised by either (a) improving the symptom checklist so all psychiatrists and NPPs complete it consistently or (b) requiring that psychiatrists state explicitly the symptom each psychiatric medication is being prescribed to treat.

The QAI Review of Taberg noted that two of four records of girls prescribed psychiatric medication, there was no evidence in the Psychiatrist Contact Form for rationale or target symptoms for medications. Of four girls reviewed by QAI, the psychiatrist met weekly with one, bi-weekly or weekly with another, and monthly with another not prescribed medication. The QAI review raised concerns about one youth admitted to Taberg in March 2013 taking psychiatric medications reportedly not being seen by the psychiatrist until May and not again after May. That youth was at Taberg at the previous site visit, a 16-year old admitted 3/7/13 to the MHU for resisting arrest. She was listed on the 3/19/13 medication list as prescribed Mood Disorder-Trileptal, Anxiety-Clonidine and Welbutrin, and Insomnia-Bendryl and was noted in the monitoring report as one of five Taberg residents receiving four psychiatric medications. In response to a request from the MH Monitor, OCFS indicated that she had psychiatrist contact notes in JJIS for 5/2; 5/9; 5/23; 5/30; 7/23; 7/30; and 8/13. In August, she was prescribed five psychiatric medications: Mood Disorder-Risperidone and Welbutrin, Conduct Disorder-Clonidine and Lamictal, and Insomnia-Trazadone. She was transferred to Bronx CMSO on 8/22/13

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, two Taberg residents were prescribed four psychiatric medications and several had more than one medication per class, as described in more detail below.

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.

The QAI Review raised concerns about quarterly labs for girls prescribed psychiatric medication, but in the records reviewed by the MH Monitor, labs were documented. The MH Monitor will continue to review records for quarterly labs.

On Site Observations Regarding Paragraph 49a-c (9/13)

On September 24, 2013, 14 of the 19 girls in residence at Taberg had psychiatric diagnoses and were prescribed psychiatric medication:

ADHD - Risperdone (2)
Anxiety - Clonidine and Topomax
Anxiety - Prozac
Bipolar - Depakote
Conduct Disorder - Lamictal and Vistaril
Depression - Clonidine and Effexor
Impulsivity - Zyprexa
Insomnia - Trazodone (4; including a girl also prescribed Melatonin for Insomnia)
Mood Disorder - Celexa
Mood Disorder - Clonidine
Mood Disorder - Effexor
Mood Disorder - Intuniv (2)
Mood Disorder - Zoloft
Mood Instability - Seroquel (a girl also diagnosed with Mood Disorder for which Clonidine was prescribed)
PTSD - Celexa (2)
PTSD - Zoloft and Seroquel

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

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." In September 2013, three Taberg residents were prescribed three psychiatric medications and two were prescribed four psychiatric medications:

Clonidine, Effexor Trazodone
Clonidine, Seroquel, Trazodone
Intuniv, Risperidone, Zyprexa

Intuniv, Lamictal, Risperidone, Vistaril
Seroquel, Trazodone, Zoloft, Melatonin

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.

In the MH Monitor's review of the 43 youth prescribed psychiatric medications in July, 2013 described above, overall 49% of the residents of the three facilities were prescribed psychiatric medication (43 of 87) as compared to 43% (36 of 83) in January 2013. In July 2013, there were divergent medication practices among the four psychiatrists and two NPPs at Columbia, Finger Lakes, and Taberg. Finger Lakes continued to have a much lower percentage of prescription of psychiatric medications (36%) in comparison to Columbia (67%), and Taberg (75%). Even given the small numbers analyzed, there are noteworthy different rates of prescribing medications. The most commonly prescribed psychiatric medications by facility were: Taberg-Seroquel (33%) and Trazodone (27%); Columbia-Remeron (25%) and Adderall (25%); and Finger Lakes-Seroquel (25%) and Clonidine (20%). Comparing January and July 2013, the percentage of youth prescribed Seroquel (23%), Clonidine (16%) and Risperdal (14%) remained the same in the three facilities combined and the percentage of youth prescribed Trazodone decreased (from 27% in January, 2013 to 16% in July, 2013). At Taberg, the use of Trazodone remained the same (27%) while the use of Seroquel increased from 8% to 33% and the use of Clonidine dropped from 25% to 20% and Risperdal 25% to 13% from January, 2013 to July, 2013. At Columbia, the use of Trazodone dropped from 50% to 13%, while the use of Remeron increased from 18% to 25% and Adderall from 9% to 25%; at Finger Lakes, the use of Seroquel and Clonidine remained the same from January 2013 to July 2013. There has been national attention to reducing the prescription of Seroquel in facilities because of the dangers of side effects and abuse after return to the community. In this site visit two Taberg residents were prescribed Seroquel, a noteworthy reduction since the last site visit.

In the DOJ facilities in July 2013, Seroquel was being prescribed for Mood Disorder, PTSD, Mood Dysregulation, Anxiety Disorder, Adjustment Disorder, and Conduct Disorder. Trazodone was being prescribed for Insomnia, Major Depressive Disorder, Depression and PTSD. Clonidine was being prescribed for Anxiety Disorder, ADHD, PTSD, Depression, Insomnia, and Conduct Disorder. Risperdal was being prescribed for ADHD, Mood Disorder, Disruptive Behavior Disorder, and Conduct Disorder.

FUTURE MONITORING

The MH Monitor will review additional psychiatry guidelines.

The MH Monitor will review consistency of tracking diagnosis, symptoms, efficacy and side effects of psychiatric medications 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 OCFS the practice of prescribing four psychiatric medications and more than one medication per class to residents.

The MH Monitor will continue to review records for quarterly labs.

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.

FUTURE MONITORING

The MH Monitor will continue to review documentation that Taberg staff are adequately trained about mental health and informed about residents' medications.

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.

The QAI Review at Taberg raised concerns that the support team, including the youth's parent/guardian/caregiver should discuss a youth's refusal to take prescribed psychiatric medication.

On Site Observations Regarding Paragraph 51a-e (9/13)

The MH Monitor observed documentation in a Taberg record when a resident refused psychiatric medication and follow-up by the nurse and psychiatrist.

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 person(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 (9/13)

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

FUTURE MONITORING

The MH Monitor will continue to review documentation of informed consent for psychiatric medications at Taberg.

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

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

COMPLIANCE

The New York Model implementation training included the integrated assessment and support plan (formerly treatment plan), and how to utilize both in support teams (formerly treatment teams). "The NY Model: Treatment Team Implementation Guidelines"

complies with 53a. BBHS has revised the support plan and the integrated assessment and guidance is being provided 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. A psychiatrist participated in one of the support teams observed by the MH Monitor at Taberg.

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 clinician and not something she wants discussed with her 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. Consistently strong support plans—including building from the Integrated Assessment, stating 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. Helping a resident articulate her goals and encouraging each staff person on her team to identify what he/she will do to support the resident's daily steps to achieve her goal is time-consuming, and an insufficient number of clinicians will make it difficult for Taberg to comply with Paragraph 53.

"Goal Writing and Support Plans in the New York Model" (4/12/13) provides helpful, specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and validating them as they talk about the outcomes they want, building on strengths to build on to achieve their goals is stressed as an important part of writing support plans. The one-page Goals Worksheet is for staff to help youth identify their goals 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. The one-page Support Team Staff Notes walks staff through an analysis of their role in assisting a youth achieve goals. 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 were not being implemented consistently yet at Taberg, but they were working at improving support plans (see the 10/13 exemplary support plan for [redacted] described below). Almost all of the Taberg support plans have a standard goal of wanting to return home—this may be the general goal of all residents, and must be presented in an individual-specific context. Making the goal a specific change the resident will make so she can be successful at home helps her understand why learning particular skills is important and a choice she is making to avoid getting in trouble again.

Some support plans tie this goal to learning distress tolerance, but why this skill is necessary to go home may not be apparent to the resident. It is likely that they cannot regulate their emotions if they do not receive trauma treatment, and reducing reactivity from past trauma would require different interventions for each resident.

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

COMPLIANCE

Mental health staff at Taberg were observed complying with 53f.

On Site Observations Regarding Paragraph 53a-f (9/13)

The MH Monitor observed two strong Taberg support team meetings, both of which showed Taberg staff with commendable relationships with residents communicating effectively with family and CMSO. [redacted] is a 16-year old at Taberg since 1/13 for assaulting [redacted] when she was 14. She has a diagnosis of PTSD and is prescribed Celexa. She was involved in a group assault on a Taberg resident and her discharge date was cancelled; it will be re-set after she goes to court in 10/13. In her support plan Goal #1 was "I want to go home and stay home." She was supposed to identify and discuss trauma, including triggers and what would help her feel safe at home, but none of the interventions listed for staff, including her clinician, mentioned trauma. Her Goal #2 was "I want to finish high school, go to college and be a social worker." Her plan also called for weekly family therapy on the phone because she and her family want to re-establish trusting relationships. Her support team was convened by her YC, with her clinician, teacher, the other clinician on her unit, the nurse, the Mid-Hudson CMSO and B2H provider representative. No YDA was present and there was no mention of a mentor. Initially the team discussed whether she was sabotaging her discharge, asking about her worries about going home. [redacted] arrived at the meeting and was happy to hear her father's voice on the phone; she greeted the CMSO cheerfully. Her YC reviewed her IIP carefully with her and revised it. She said she is using Radical Acceptance and pros and cons and her clinician showed appreciation for her progress. Her father told her she has to make amends to people at home, and she agreed. The meeting dragged when her support plan was read out loud. Her clinician said in weekly therapy they will start talking about how substance abuse might be related to trauma and how to deal with them to achieve her goals of high school graduation and college. Her clinician also talked about carry-over of skills to the community. Her YC and clinician were appreciative of her family, her father responded gratefully, showing exceptional rapport between Taberg staff and family. In the debrief, her YC and clinician said they are pleased about what they are doing in support teams now. The teacher described being a valued member of the team. Moving support teams to much better space in the Annex has also been an improvement. Her YC and clinician were emphatic that it is a Taberg goal to include YDAs in team meetings, particularly mentors, but this is a scheduling issue especially when mentors work evening shift.

[redacted] is a 12-year old who continues to be the youngest Taberg resident; she has been at Taberg for [redacted] a year (10/12) for aggressive behavior at [redacted]. She had lead exposure and repeated head injuries as a child, was abandoned by her parents, set a fire in [redacted] when she was five and was expelled in 2nd grade for aggression. Testing at Taberg found that she had a full scale IQ of 62, the receptive language abilities of a 4-year old and the social skills of a 5-year old; her processing of simple visual material and her short-term memory were severely impaired. Her initial diagnosis was ADHD, Disruptive Behavior Disorder, Rule Out Mood Disorder, Borderline Intellectual Functioning, Rule Out Mental Retardation. Her foster care, medical, psychiatric hospital, and [redacted] records were not in her Taberg record and would contain essential diagnostic information. An additional concern is that a neurological or

neuropsychological evaluation were recommended by reception, and the Taberg psychologist completed intelligence testing, but the effects of head injury were not clarified, and would be crucial for intervention. Her support plan indicated that her assaultive behaviors and restraints had decreased. One-to-one attention was effective with her and she has a strong relationship with the nurse. She was beginning to be able to express fears about going home to her [redacted] and having contact with her [redacted] who was recently released from prison. Residential placement appeared to be the preference of staff, but admission was being sought to Tradewinds day school with B2H services in her aunt's home; a recent CSE meeting had been held at Taberg. Her Goal #1 was "Go home to [redacted] and stay home," which involved making the connection between trauma and problems with emotional regulation. The role of each member of the team in validating her when she expresses feelings and offering 1:1 was clearly defined. Her Goal #2 was "Get along with [redacted] Her current diagnosis was Reactive Attachment Disorder, Mild Mental Retardation, and Conduct Disorder. Her support team meeting was convened by her clinician with the nurse, psychiatrist, teacher, YC, YDA-Mentor, vocational teacher, and the aftercare worker and CMSO supervisor. The CMSO commented that he was at Taberg a few weeks earlier for a Red Flag meeting and was impressed with the teamwork and rapport the team had with [redacted] She arrived at the meeting and her aunt participated by phone. [redacted] said she asks for Time Away and is learning to control herself. Her mentor drew her out in the meeting, but the CMSO lectured her. Placement with her aunt was discussed further. The meeting showed a collaborative support team with resident, family and CMSO involvement. In the debrief, her clinician commented that she showed a lot of improvement in her in participation in the meeting. The psychiatrist noted that she has gained a lot of weight, but when medications have been decreased, she gets out of control; she is converting her to weight-neutral medication. Her aunt's unwillingness to let [redacted] be placed elsewhere is problematic; in almost a year, her aunt has not agreed to family therapy, has only made three visits, and did not attend the Tradewinds interview. [redacted] will not talk to her aunt about her feelings. Given [redacted] limitations and need for one-on-one support, it seems inevitable that even with a strong day school program, placement with an ambivalent relative is destined to fail. A treatment foster home (for example, a program like Multidimensional Treatment Foster Care) would fit her needs, but apparently is not something the Taberg staff can arrange.

The BBHS Facility Clinical Procedures (with instructions for clinical documentation in JJIS) include: accessing reception assessments in JJIS, mental status exam (including ISO-30), IIP, safety plan, integrated assessment, support plan, psychiatric diagnostic assessment and psychiatric contact notes, uniform working diagnosis, clinical contact notes (for individual and family sessions), group contact notes (DBT and psychoeducation groups), referral forms to discrete treatment units, discharge planning and Continuity of Care plan. The BBHS Facility Clinical Procedures clearly present both clinical practice expectations and instructions for documenting clinical services. The BBHS Facility Clinical Procedures could be strengthened by describing the special role of the clinician in Red Flag meetings and Mental Health Rounds where the clinician models examining what contributed to a youth's behavior and integrating information from assessment and trauma history to support other staff in adjusting their actions to meet the youth's needs, especially to prevent escalation.

The BBHS Facility Clinical Procedures emphasize how to write goals and objectives, interventions including substance abuse, and a narrative of the youth's progress each review period. "All clinicians are expected to provide individual therapy, group facilitation and regular family contacts to assist youth and families in making progress toward their objectives and goals." The revised Integrated Support Plan format on JJIS includes a clearer way of writing each goal and interventions to support the young person in meeting that goal as well as sections on the youth's current functioning and progress made toward goals, family strengths and family goals.

"The New York Model: Youth Support Team Implementation Guidelines, BBHS" includes functions of the support team meeting, support team documents, process of and procedure for support teams, integrated assessment instructions, and guidelines for facility medical departments. "The Support Plan is the answer to this question: "How will we help this youth (what resources or supports can we offer?) to progress from where s/he is currently (assessments, strengths, motivations, 'potential'), to where they hope to be (goals), given their current circumstances (needs, vulnerabilities, obstacles)?" The guidelines clarify the reason for a two-part support team meeting, and the importance of beginning the second part of the meeting with the youth and family present with strengths and "a sense of hopefulness and capability." The Guidelines continue, "When progress does not occur, the entire team takes responsibility for the plan and rewrites the plan in an effort to assist the youth in moving toward their goal." The Youth Support Team Implementation Guidelines example of interventions for a youth with attention difficulties could be strengthened by including interventions of team members other than the psychiatrist, clinician and educator; guided by those team members, the youth's mentor and other YDAs play key roles in assisting with building attention skills individually and in groups, the recreation specialist could do so in games and exercise, and the vocational instructor could help find a work activity where the youth excels even with attention limitations.

The QAI review of Taberg concluded that continued improvement is needed in the overall content and quality of support plans, especially establishment of measurable, attainable and appropriate treatment goals that are transferable to the community, objectives that outline how the youth will reach the goals, and interventions that connect support team members and inform the youth how each team member will help her advance toward her goal. More BBHS coaching of clinicians on goal writing and improving the individualization of support plans is needed, especially in applying "Goal Writing and Support Plans in the New York Model." The QAI Review described observations of two support team meetings at Taberg that were positive, thorough, listed interventions for staff, and were inclusive of family. Two meetings actively involved CMSO; two did not. In one meeting, the youth left confused and upset, not understanding why it would take another 60 days for her to be released.

FUTURE MONITORING

The MH Monitor will continue to review Taberg support plans for specific needs unique to that resident, building from the Integrated Assessment with clear goals based on the resident's aspirations as well as staff expertise about trauma and other challenges for her, and all team members' interventions being specified.

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

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

The OCFS substance abuse manual defines practices that comply with 54a.

Taberg is providing InnerVisions groups for residents.

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.

COMPLIANCE

The OCFS substance abuse manual defines practices that comply with 54a.

Taberg is providing Triad groups for residents.

Taberg clinicians, as noted in individual support plans, provide individual therapy regarding substance abuse for residents with a substance abuse diagnosis. The MH Monitor did not see any records in which a clinician assisted a resident in completing a relapse prevention plan.

On Site Observations Regarding Paragraph 54a-b (9/13)

The final version of the OCFS substance abuse manual was reviewed and integrates substance abuse prevention education and treatment into the New York Model. The Substance Abuse Services Training and Procedure Manual is thorough and includes chapters on Adolescent Substance Abuse, the Continuum of OCFS Substance Abuse Services, New York Model Phases and Substance Abuse Treatment, and Transition Planning and Community Care. The progressive self-awareness, response to mentoring, and use of skills listed for each phase is particularly helpful and has an emphasis on relapse prevention.

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 therapy and DBT and Sanctuary groups. Strong communication in support teams and Mental Health Rounds among the clinicians, YCs, and YDAs and the rest of the team is necessary to support each Taberg resident's individual progress in self-calming and relying on these skills to avoid substance use in the community.

The MH Monitor observed two well-led substance abuse groups at Taberg: Innervisions with one unit and TRIAD with another unit.

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. 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.

Substance abuse treatment was integrated into the exemplary support plan of [redacted] a 16-year old who had been placed in Close to Home at [redacted] she ran away and had an altercation with a staff person, and in 3/13 was placed at [redacted] but after she ran away, the judge ordered her to medium security with a minimum stay. Her diagnosis was PTSD, Cannabis Dependence, and Conduct Disorder. Her Goal #1 is to become a professional singer, with an objective of remaining abstinent from smoking marijuana because it harms her voice. Each member of the team's role in supporting her in meeting her goal was described, including her clinician both helping her explore her trauma and connect her trauma to her use of marijuana and her mentor and YC also coaching her on not using substances. Her Goal #2 was to graduate from high school, with an objective of increasing classroom participation and attendance at Taberg and transition home. Each team member was to provide daily school support, her clinician was to help her use DBT skills to improve emotional regulation so she could stay in class, and education had several roles assigned. Her clinician also had several activities to assist [redacted] and her mother in improving their relationship. Each team member also contributed thoughtful comments on her progress.

The QAI Review described observation of an Innervisions group, indicating that it is offered bi-monthly with the Triad treatment group meeting in between. Seven youth and two YDAs attended and one clinician and one YDA co-facilitated the group on the unit. "Both facilitators were patient, knowledgeable of the material, interactive, and had strong connections with the group participants. The youth's experiences were drawn upon and incorporated into the group discussion, the tone of the group was positive, and the participants were engaged."

The QAI Review concluded that none of the five Taberg residents reviewed were consistently receiving Innervisions. One resident had a substance abuse diagnosis and was attending week substance abuse group but was not receiving individual substance abuse counseling. A second resident had a substance abuse diagnosis and was neither attending substance abuse group nor receiving individual substance abuse counseling. A third resident had a substance abuse diagnosis and was receiving individual substance abuse counseling but not attending consistent substance abuse groups. One resident did not have a substance abuse diagnosis, but there was no record of consistently participating in Innervisions. The QAI reviewers noted that in the absence of an Assistant Director for Treatment the substance abuse clinician had been attempting to balance multiple roles. During the site visit, the MH Monitor observed Innervisions and Triad groups and saw them on the regular schedule. The MH Monitor concurs with the QAI Review that a substance abuse clinician must have the time to provide groups consistently and support other staff in doing so. Through support plans and support teams, the substance abuse clinician ensures that other clinicians are integrating trauma-responsive individual drug treatment in therapy and doing relapse prevention plans with residents before they leave

Taberg. An insufficient number of clinicians will make it difficult for Taberg to consistently demonstrate compliance with Paragraph 54.

FUTURE MONITORING

The MH Monitor will continue to review documentation of 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, including the preparation of 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 revised Discharge Summary includes sections on Background Information, IIP, Progress Toward Goals (with goals), Medication, Diagnostic History, and Discharge Plan and complies with 55b.

Taberg staff are not completing Discharge Summaries.

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 (9/13)

Discharge Summaries should define how a resident's support plan and gains in the facility will continue in the community. The resident's goals should be transferable to the community, and that is a major purpose of the last support team meeting before re-entry and of the Discharge Summary, so supporters in the community understand their role in helping the youth regulate emotions, tolerate distress and avoid relapsing. Through the New York Model OCFS has implemented the integrated assessment and integrated support

plan, and Discharge Summaries should result in an integrated transition that includes all elements of a youth's successful re-entry to the community.

Two Taberg residents' re-entry problems demonstrate the weakness of discharge planning. [redacted] was a 15-year old who was placed on the Taberg mental health unit in 11/12 (her offense was [redacted]). She had multiple placements and psychiatric hospitalizations and had been removed from home by DSS for medical neglect, sexual abuse, witnessing domestic violence, and a lack of parental supervision. She had tested IQs that ranged from 61-73, and both her parents had limited cognitive abilities and mental health diagnoses. [redacted] support plans had the same two goals for months at Taberg: "No longer exhibit self-injurious behavior" and "Graduate high school and become a nurse or veterinarian." During her Taberg stay, self-injurious behavior decreased substantially and Risperidone had been discontinued. Although originally diagnosed with PTSD, her discharge diagnosis was Conduct Disorder, Cluster B traits, Borderline Intellectual Functioning. During the previous site visit, staff expressed the view that [redacted] should not have to leave Taberg after six months. Nevertheless, she was discharged to House of the Good Shepherd 6/20/12, with the Taberg psychiatrist hoping that her relationship problems, social skill deficits, and being hypersexualized and reactive would be treated there. After going AWOL and cutting, she was hospitalized at Pinefield on 6/23/13, returned to HGS on 7/19/13, returned to Pinefield later that same day, and return to Taberg on 7/25/13. Meanwhile DSS, without telling Taberg staff, asked the court to close her case. In the six weeks before this site visit she had five individual sessions with her clinician (plus seven suicide evaluations by her clinician), four medication reviews with the psychiatrist (for Celexa), seven individual sessions with her YC, one Innervisions and two TRIAD groups, and three DBT groups, Staff commented, "We didn't think HGS would work out [at HGS], but had to move her out." OCFS is now doing a home study: "if it comes back negative, we will be able to send her to a secure step-down and keep her safe until she's 18." Whether a secure residential facility that she cannot run away from will also have the services to meet her trauma-related needs is unknown. Her parents' continuing pressure to return her home likely makes her think she should live with them.

[redacted] is a 16½-year old whose first stay at Taberg was 11/12-5/13. She was a bright college-bound substance abuser who had been abused and has a conflicted relationship with her immigrant parents. She was placed in a NYC residential program for violating probation and then at Taberg for violating the conditions of her release. 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 self-harming behavior. Her diagnosis was Conduct Disorder (by history), Polysubstance dependence, Rule Out PTSD. Her Goal #1 was "To return home" with the objective of decreasing anger, and the interventions were individual therapy, weekly counseling, and school encouragement. Her Goal #2 was blank with an objective of increasing trust in others. It was evident she would likely require considerable assistance to identify the skills and the support necessary to avoid relapse in the community. She was released on Abilify, Intuniv, Prozac and Trazodone with an appointment at YMCA

Counseling Service for mental health counseling, psychiatric, and substance abuse treatment; family therapy was listed in the Continuity of Care plan as not indicated. Although she had made considerable progress at Taberg, [redacted] returned a few months later, having relapsed and experienced the same problems at home. She returned more depressed because of trauma that occurred while she was gone. In the three weeks since she returned at the time of the site visit, she had three individual sessions with her YC, two individual sessions with her clinician (plus three evaluations for suicide watch) after her former therapist transitioned her as the therapist was leaving Taberg, one DBT group, one Innervisions group, one TRIAD group, and one psychiatric medication review for Clonidine, Effexor, and Trazodone. The psychiatric note indicated that she still wanted to return home to protect her mother from her father's physical abuse. She was depressed, irritable, felt guilty, had resumed self-injurious behavior, suicidal ideation, and impaired sleep.

Both these residents had serious family problems that were minimally addressed at Taberg during their six/seven month stays (due to parental cognitive limitations in one and distance and employment schedule in the other). It was unrealistic to expect, despite the inidividual progress both made, that outpatient counseling or residential treatment would be sufficient support to continue the gains they made at Taberg. For both it appears that more intensive treatment and making peace with not being able to be successful if they returned home was essential, along with strong community support for skills learned at Taberg to prevent self-harming behaviors. The current work with these girls is not trauma-responsive. It urges girls to stop their self-injurious behaviors, but treatment for what drives self-harm is not provided. The girls are discussed in terms of the ups and downs of their daily peer problems and depression symptoms, but not in the context of what it will take for them to recover from trauma. Possibly this lack of more informed treatment is a result of the clinicians being so stretched and/or insufficient collaboration among the clinicians and psychiatrists.

Systemic placement problems continue to reduce Taberg's effectiveness, so girls leave and return when staff knew they were not likely to get their needs met in their discharge placement. This is harmful for girls and discouraging for staff. Unsuccessful discharges are avoidable in less rigid systems that value reunification and also recognize that sometimes a girl cannot be safe at home even with aftercare, B2H and mental health/substance abuse services. Specialized treatment foster homes bridging to well-supported independent living programs are needed in the array of re-entry services available for Taberg residents.

FUTURE MONITORING

The MH Monitor will continue to review documentation that Taberg produces thorough Discharge Summaries and that, along with Continuity of Care plans, they support the continuation of the resident's progress in the facility in the community.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

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

COMPLIANCE

COMMENT: This and the previous monitoring visit generated no concerns about Paragraph 56.

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Taberg Residential Center for Girls* (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 produces excellent reports, 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 participated in a conference call with QAI staff members on September 20, 2013 to discuss the Taberg report. In addition to both monitors, those on the call included David L. Bach, Director QAI; Sandra Carrk, Project Manager; Lori Clark, Quality Assurance Specialist; Diane Deacon, Assistant Deputy Counsel OCFS; Myra DeLuke, Quality Assurance Specialist; Edgardo L. Lopez, Settlement Agreement Coordinator; Robert MacGiffert, Assistant Director QAI; Jennifer Mack, Quality Assurance Analyst; Anne Pascale, Chief of Treatment Services; Denise Passarello, Quality Assurance Specialist; Michael Rotolo, Quality Assurance Analyst; Hilda Saltos, Quality Assurance Analyst; Jennifer Utting, Quality Assurance Specialist. The high-quality QAI Reports are becoming an important resource for ongoing OCFS assessment of Settlement Agreement issues.

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[1] 68. Document development and revision. The State shall timely revise and /or develop policies and procedures, forms, screening tools, blank log forms, and other documents as necessary to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement.

QAI has proposed a quality assurance strategy that could lead to an expedited finding of compliance for the Protection from Harm paragraphs when fully developed and implemented. In its efforts to assist the facility in the appropriate use of physical restraint interventions, QAI reviewed with the Monitors the development of restraint metrics that would be linked to graduated response protocols or safeguards and action plans. More importantly, this QAI initiative has recognized the paradigm shift that occurred in juvenile corrections nearly two decades ago and is consistent with generally accepted professional standards. These critical 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.

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

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

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

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

V. SUMMARY

One staff member captured it best by describing the goals for the future as the continued reduction in the use of restraints and the continued increase in de-escalation skills. Regarding the reduction in restraints, Taberg should consider the strengthening of the Therapeutic Intervention Committee (TIC). Home Office relies on a strong TIC to generate the ideas and strategies that will reduce restraints. To accomplish this goal, the facility TIC should analyze restraint events and patterns more thoroughly. Some recommendations include: increasing the number of YDA and YC staff members on the TIC; a greater involvement of treatment staff in the review of restraint events, particularly the review of the video, to provide specific feedback about the YDA staff members use of New York Model concepts; the designation of a restraint specialist, coach, or lead person, whose full-time responsibility is the review and analysis of use of force practices; and a renewed emphasis on strengthening de-escalation skills and the use of effective de-escalation to avoid restraints; units being guided to examine days and times of the highest number of restraints and design unit-specific ways to enhance staff support for residents' self-calming especially during those stressful intervals.

Change has occurred quickly and dramatically as a result of the Settlement Agreement. Taberg is implementing the New York Model and has an increasing number of paragraphs with sustained compliances. Several recommendations for continued strengthening of the New York Model integration with the YDA staff at Taberg include:

1. Continue to expand YDA staff involvement as providers of primary interventions to support residents in achieving their goals. This includes more, and more consistent, communication with YDA staff on all shifts and strengthening the YDAs' role in the TIC, support teams, and Mental Health Rounds. It might be helpful if Mental Health Rounds

sometimes occurred in the afternoons to include the second shift. This may mean increasing the number of YDA and YC staff designated as members of the TIC.

2. Increase clinicians' input in the administrative review of Restraint Packets required by Paragraph 42e so that the determination of Documented Instruction and coaching can be enhanced through the New York Model perspective about alternative ways to resolve the still too frequent conflict between therapeutic problem solving versus rule following during conflict situations.

3. Take into account the advantages of a restraint specialist, coach, or lead person, whose primary responsibility is the review and analysis of use of force practices.

4. Ensure that once Taberg has an Assistant Director for Treatment and Assistant Director for Program, the full allotment of YCs and clinicians is in place so the coaching team at Taberg is not as stretched as they have been for more than a year. Clinicians do therapeutic work with residents and YDAs implement the DAS and other elements of the New York Model, but when a resident gets under particular stress, she requires assistance in self-calming that relies on stronger support of the YDAs by the clinicians. Taberg staff want to prevent the repeated deterioration of residents prior to discharge, and this is an another example of something that requires close teamwork of clinicians and YDAs.