MONITORING REPORT FOR THE SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES AND THE STATE OF NEW YORK IN THE MATTER OF *UNITED STATES V. THE STATE OF NEW YORK and THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES* (U.S.D.C. NORTHERN DISTRICT OF NEW YORK)

Facility Monitoring Report:
Taberg Residential Center for Girls
Taberg, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

TABERG RESIDENTIAL CENTER FOR GIRLS

Taberg, NY

I. INTRODUCTION

This is the twenty-second 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 April 21-23, 2015. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

A. Facility Background Information

Taberg is a 24-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 11 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 operates as an integrated mental health program with the same mental health and substance abuse services offered to residents on both units.

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.

On April 21, 2015, there were 17 girls in residence at Taberg (an additional girl on the roster had absconded from court). Nine of the girls at Taberg in April, 2015, were there during the monitoring visit in December, 2014.

The 17 girls ranged in age from 14 to 17. Eleven girls were 14 and 15, with two 16-year olds and four 17-year olds. The 17 girls had been at Taberg from 19 days to 460 days; this average length of stay of 5 months is longer than the Taberg average in previous site visits. Only four had been there two months or less, half had been there 2-6 months, and three had been there a year or more.

The 17 Taberg girls had been sentenced for: Criminal Mischief (5), Assault (4), Petit Larceny (4), Menacing (2), Robbery (1) and Impersonation (1).

Twelve of the 17 Taberg girls have psychiatric diagnoses, and most have more than one: ADHD (1), Anxiety (2), Depression (2), Disruptive Mood Dysregulation Disorder (2), Mood Disorder (5), and PTSD (1); six are diagnosed with Insomnia and one is diagnosed with Conduct Disorder.

Twelve of the 17 Taberg girls are prescribed psychiatric medication: Abilify (4), Benadryl (3), Trazodone (2), Celexa (1), Depakote (1), Effexor (1), Geodon (1), Intuniv (1), Lamictal (1), Lexapro (1), Melatonin (1), Prozac (1), Seroquel (1), Vistaril (1), and Zoloft (1).

Ten of the 17 Taberg girls had a SNAP score of 3 or higher and/or a substance abuse diagnosis. Seven had a SNAP score of 3; three had a SNAP score of 4. Three have a diagnosis of Cannabis Abuse and three have a diagnosis of Polysubstance Dependence. Seven of these 10 girls are prescribed psychiatric medication (including four prescribed atypical antipsychotics).

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. The Monitors were given OCFS' eighth Six-Month Progress Report on the Master Action Plan (MAP) on December 18, 2014 and the ninth Six-Month Progress Report on June 17, 2015 prior to filing the draft report.

3. Entrance and Exit Interviews

The entrance interview occurred on April 21, 2015 with the Monitoring Team and OCFS representatives, including key staff members from the facility. The exit interview occurred on April 23, 2015. A complete list of attendees of the entrance and exit interviews is available upon request.

4. Facility Tour

Walkthroughs of the facility occurred throughout the visit.

5. On-Site Review

The site visits 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 assessments. The MH Monitor observed two support team meetings, a phase advancement meeting, Mental Health Rounds, an intact team meeting, a DBT group, a substance abuse group, the TIC, a pre-shift briefing, met with clinicians/coaches, met with Home Office and facility administration and reviewed eight residents' records. The PH Monitor's direct observations included the facility Therapeutic Intervention Committee (TIC).

6. Staff Interviews

The Monitors interviewed 24 Taberg staff. In addition to group meetings with staff, the MH Monitor interviewed three clinicians, two Youth Counselors (YCs), a YDA and two nurses. The PH Monitor interviewed one Facility Manager, one Facility Director, 6 Youth Division Aide (YDA) staff, the Assistant Facility Director for Treatment, one Youth Counselor, one psychologist, 2 Bureau of Training trainers, one Administrator on Duty (AOD), one teacher, and 2 nurses.

7. Resident Interviews

The MH Monitor interviewed three Taberg girls, and the PH Monitor conducted interviews with 5 girls with an average age of 15.6 years. Interviews occurred in areas with operating surveillance cameras and reasonable privacy from staff.

C. Preface to Protection from Harm and Mental Health Findings

The April, 2015 site visit revealed staff working to return Taberg to a stable, calm environment where residents can make progress. At the time of the site visit, the unusually low population and strong intact teams, even given continuing vacancies, resulted in more girls feeling safe and being proud of using their new skills.

Taberg had emerged from period in 2014 where multiple sexual abuse allegations and the unintended consequences of these unfounded allegations quickly destabilized staffing and eroded safety, security, and structure. Ultimately, the Home Office perspective on the variables that contributed to the false allegations settled on the lack of continuity in clinical personnel, including the loss of clinical staff and the influx of new clinicians. The Home Office perspective makes sense considering how the variables preceded the change in youth behavior and how the inability to resolve the clinical staffing transitions quickly seemed to match the unrest among the youth population. Therefore, a reasonable preventive strategy for this type of disruption would focus on clinical staff stability as measured by a treatment team fully staffed with clinicians who work effectively with youth and one another in the implementation of the New York Model.

However, because of strong leadership at Taberg, a greater emphasis may have been placed on the importance of the role played by the transition of clinicians in 2014, underestimating how the continuity and stability in leadership may have kept the crisis from becoming substantially worse.

The Monitors' interviews in the April, 2015 site visit with Taberg staff provided primary- and secondary-source information about impending changes in key leadership and clinical positions. The likelihood of an extended risky period again that would include staff vacancies, prolonged searches for replacements, the presence of substitute and temporary leaders and clinicians, and general loss of stability for a vulnerable population of youth predicted problems similar to those experienced in the spring and summer of 2014. For these reasons, the Monitors requested a meeting with Home Office staff to discuss plans if a large turnover in leadership and clinical staff occurred at Taberg.

II. PROTECTION FROM HARM MONITORING

Issues surrounding protection from harm are decidedly mixed at Taberg, and multiple changes in compliance determinations have occurred. Similarly, many improvements and positive outcomes were noted in the QAI Report and outlined to the Monitors during the entrance meeting. Noteworthy were the improvements in communications, a greater sense of community, an increased YDA emphasis on relationships, and the strengths-based focus of Support Teams.

Home Office has worked hard to address the range of issues at Taberg, including technical assistance from the veteran Facility Director at Industry who provided several days of on-site assessments and consultation at Taberg. He recommended the development and implementation of a track system. The track system would divide each living unit (Amethyst and Opal) into two smaller groups creating two teams within the unit. The approach parallels the Intact Team concept that has worked so successfully at Finger Lakes, and it strengthens the beneficial processes of mentoring and counseling. He also offered several constructive recommendations, many of which seemed consistent with Home Office objectives for the Facility Director. However, one significant observation was that there simply were not enough administrative staff to implement the existing Taberg systems effectively. Additionally, Home Office provided New York Model and recreation training and coaching for Taberg staff.

In response to the Monitors concern about mechanical restraints, Home Office proactively addressed the duration of the use of handcuffs through a December 5, 2014 memorandum to all facilities implementing safeguards requiring the approval of the Deputy Commissioner of the Division of Juvenile Justice and Opportunities for Youth (DJJOY) to extend the use of handcuffs beyond a certain time threshold. The Home Office constraints on mechanical restraints are a positive action.

A. Threats to Protection from Harm

Disruptions to the structure, order, organization, and perceptions of safety affected Protection from Harm: 1) the increases in the frequency of Personal Safety and the Suicide Watches; 2) GRS changes from "green" to "yellow" (March 2014) and "yellow" to "red" (April 2014 through January 2015 and March 2015); and 3) a negative impact on the mental health status of some of the girls. Innovative strategies to reduce possible harm to other residents are more reflective of the current state of anticipating and preventing re-traumatization. However, use of force data remain somewhat fluid, which suggests that Home Office and Taberg efforts to restore Protection from Harm factors to a pre-March 2014 level have not fully taken root or other challenges are working to the contrary.

1. Staffing

The QAI Report is an excellent resource, and the continued quality improvement assessments include a brief review of staffing issues. The acknowledgment of staffing issues by QAI reflects a high level of thoroughness by addressing systemic issues that have an impact on Protection from Harm. Even though minor disagreements exist between QAI and the PH Monitor about how staffing analyses should be conducted, QAI makes the case for staffing as a remedial issue at Taberg.

Staffing remains a priority concern and the absence of an adequate number of YDAs available to work all three shifts during the week affects Protection from Harm. The staffing challenge is not simply about the number of authorized positions approved as part of the annual budget. Instead, the attention on staffing numbers has to do with the availability of qualified individuals to work a shift. By qualified, most facility practitioners mean an employee who has successfully completed the hiring process, has been through the mandatory academy training, and who has acquired some appropriate job experience. Many in juvenile corrections believe that it takes a new YDA approximately 18 months to two years to acquire sufficient experience to be competent and reliable in performing the job duties.

A second major variable affecting staffing availability is leave status, in particular FMLA and Worker's Comp, and restricted duty where certain YDAs cannot work with designated youth until an investigation is completed. For example, as of April 23, 2015, 24 YDAs had a leave or restricted contact designation (11 YDA 3 staff and two YDA 2 staff were on leave status and 13 other YDA 3 staff were on a restricted duty designation). This is above and beyond the routine or normal use of sick and vacation leave factored into staffing estimates as part of the Replacement (*R*) factor.

The third variable is the number of unfilled or vacant positions, and this shifts attention to Human Resources and raises questions about how to achieve greater efficiency in shortening the time between the designation of a vacancy and a new employee participating in the mandatory preservice training. The Taberg Facility Director (FD) explained the difference between being staffed on paper versus staffed in practice. For example, as of April 23, 2015, (a) Home Office had added four (4) additional YDA relief items, but they had not been filled as of the monitoring visit; (b) six (6) YDA 2 positions have approval to be filled but their status is "processing paperwork, packet to HRO;" and (c) six (6) additional YDA 3 positions are open but unfilled with the status being "considering candidates" or "processing paperwork." The FD reported that there are a total of 12 replacement staff positions on the books with no permission to fill them. Home office provided clarification. Confusion existed as there was no hiring freeze, and Taberg reportedly had authorization to fill these positions. The situation was described as resolved at or about the time of the monitoring visit.

A discussion of staffing that includes the impact on Coverage and Assignment of these variables would likely present a different picture of staffing adequacy than is conveyed to the Home Office and the Monitors in the QAI Report. However the concern about staffing does not stop at the YDA level. The instability at the middle-management level continues, so much so that Home Office's technical assistance provider noted that the

Taberg FD's primary obstacle was the absence of staff, particularly middle-management. This seems connected to the delay in appointing a replacement Assistant Facility Director-Programs and the concerns generated about how long it took to find a new Assistant Facility Director-Treatment. When combined, these circumstances may have contributed to the QAI assessment that the Taberg FD has too many responsibilities and that she needs help in the form of adequate staffing.

2. Youth Perspectives

Youth perceptions of safety continue to reflect varying concerns that they are not safe. Three of five interviewees indicated that she had feared for her safety since arriving at Taberg. Ratings of safety were 6.2 on a scale of 1 to 10. When asked what changes could be made to make the facility better, all youth mentioned more staff.

Three of five youth who were involved in a physical restraint indicated that they believe that staff tried to hurt them during the restraint. Two of five youth who were involved in a physical restraint reported they were injured as a result the restraint.

The interviewees gave the impression that youth understood how to manipulate the system to get what they want. As opposed to prior youth perspectives on the false sexual abuse allegations against staff, these youth gave the impression that the use of codes, Personal Safety Watches, and Suicide Watches were ways of getting individual attention. Taberg records indicate that there were approximately 180 special supervision watches for Taberg youth for the past six months. This equates to approximately one new watch per day. The statistic is provided for perspective because these watches require increased supervision by staff. Special watches at this level require a recalculation of the Coverage and Assignment strategy, and Home Office reports approval to hire five additional YDA staff to address this issue.

Beginning with the August 2012 monitoring visit, the PH Monitor has administered to a stratified non-random sample of Taberg youth selected by the PH Monitor from youth named on the ARTS list a survey regarding the facility using questions from the Performance-Based Standards (PbS) Project's Youth Climate Survey. Table 1 shows the changes in youth responses to the PH Monitor over the past five monitoring visits. The numbers suggest a return to pre-crisis levels in some of the areas.

These youth further told the PH Monitor that high numbers of physical restraints are a way to manipulate the system. In the absence of enough staff to conduct group and individual activities, staff are unable to respond when bullying occurs (80% answered "yes" when asked if they have been assaulted or threatened with physical assault); and restraints and personal safety watches are ways to get room time. Level of fear for safety among girls has remained constant recently, as measured by the Youth Climate Survey.

Discussions about safety during the interviews suggested several factors influencing perceptions of safety. First, youth indicated that there is not enough "good" staff to go around. This seems to effect several other perceptions. For example, not enough of these "good" staff means that several shifts will have staff members that youth do not like and, in some cases, fear (60% of youth who have been restrained believe that staff tried to hurt them during the restraint). When considering that many girls believe they are at risk of harm from other girls, the ability of staff to guarantee safety on the shift may be seen by

youth as uncertain or unlikely, and several girls suggested that the personal safety watches have been a way to get one-on-one attention and to be away from these potentially harmful peers.

Table 1. Percent "Yes" Responses to the Youth Climate Survey Questions

Question *n* =	**2013 Sept** 9	**2014 April** 8	**2014 June** 10	**2014 Dec** 10	**2015 Apr** 5
Do you understand the facility rules?	100.0%	87.50%	80.00%	80.00%	**100.0%**
Do you understand the level, phase, or points system here?	77.78%	87.50%	60.00%	60.00%	**100.0%**
Have you feared for your safety?	11.11%	37.50%	60.00%	60.00%	60.00%
Have you had personal property stolen directly by force or by threat?	22.22%	50.00%	50.00%	20.00%	**0.00%**
Have you been beaten up or threatened with being beaten up?	11.11%	50.00%	60.00%	30.00%	80.00%
Have you been involved in any fights?	44.44%	37.50%	60.00%	50.00%	20.00%
Do staff make more positive comments to youth than negative comments?	55.56%	25.00%	30.00%	50.00%	**80.00%**
Are staff members fair about discipline issues?	44.44%	12.50%	20.00%	30.00%	40.00%
If you have been restrained, do you think staff tried to hurt you?	0.00%	50.00%	55.60%	66.67%	60.00%
Within the last six months here, have you been injured?	22.22%	62.50%	60.00%	60.00%	40.00%
If yes, was the injury the result of a physical restraint?	0.00%	62.50%	20.00%	60.00%	50.00%
Have you ever made a complaint against a staff member as a result of a physical restraint?	33.33%	50.00%	70.00%	50.00%	40.00%
Within the last six months here, has anyone forced you to engage in sexual activity?	0.00%	12.50%	30.00%	0.00%	0.00%
On a scale of 1-10, with 10 being the highest, how safe do you feel in this facility?	8.44	6.29	6.08	7.60	6.4

3. Staff Perspectives

Current staff confirmed what previous staff interviews identified as the pervasive stress under which they approach each new shift. The same three themes emerged as serious problems from the perspective of staff. First, consistency has been improving but not to the point that basic behavior management strategies were more effective. Staff pointed to the Daily Achievement System (DAS) as sensitive to inconsistency in staffing assignments when the ability to know the youth well enough leads to increased reinforcement of youth who have been doing well. Second, a few staff fear that the youth are now in charge of the facility or, stated differently, that the youth have been emboldened to behave inappropriately because of what they believed to be the lack of timely consequences for misbehaviors, i. e., the admittedly false sexual abuse allegations. Third, staff expressed frustration and some fear because of their perception of a staff shortage aggravated by the stress of too much overtime.

Descriptions of Taberg staff by Taberg staff consistently included "exhausted," burned out," "stressed," "low morale," and "stretched too thin." They also attributed these problems to leave time, particularly Workers Comp where eight of 12 staff members on Workers Comp are female. The same individuals also noted the change in the supervision provided from Home Office to the FD. One teacher indicated that there was "No point in calling a code; there is no one to respond!" One middle manager said that the new motto is "There is no cavalry coming; you must save yourself." This statement was followed by an observation that Taberg remains under DOJ monitoring in large part because of the failure of Home Office to staff the facility properly. Again the distinction was made between positions on paper and people available to work the shift.

Every level of Taberg administration, middle management, and line staff on both the program and treatment sides of the Table of Organization expressed dissatisfaction with the nature and extent of the support from Home Office. A common theme was the lack of continuity due to the sporadic and temporary nature of assistance from multiple sources. One staff member described it as Home Office "swoops in" with a couple of staff, stays a day or two, changes things, and then leaves. Several staff described these short-term bursts of technical assistance as equally disruptive as they are helpful. Another staff member's perspective was that Home Office is too punitive, driven far too much by personal as opposed to professional issues, and the manner in which Home Office deals with Taberg staff is a contradiction of the New York Model because of the harshness directed toward Taberg staff. If only partially accurate, these perspectives from the individuals expected to make the changes to bring about compliance need to be resolved.

B. Use of Restraints

The Taberg GRS protocols triggered this "Red Flag" Restraint Review.

The DOJ-generated "Red Flag" Restraint Review became part of the use of force monitoring strategy as a derivative of the agreement between DOJ and the State. The "Red Flag" Restraint Review requires a more inductive approach to compliance determinations, which would have been reasonably well understood and anticipated by the State when it raised the "number of restraint" objections to DOJ. The "Red Flag" Restraint Monitoring starts 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 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" Restraint Review 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 requires a larger sampling of restraint events over a designated time, usually the period between Monitoring visits.

The "Red Flag" Restraint Review of Taberg restraint activities included a stratified, non-random sample of Restraint Packets based on the complexity of the restraint (for

example, notation of multiple restraint techniques and multiple staff members involved), the length of the restraint, preliminary indications of injuries to youth or staff or referrals of staff for investigation, and the date of the incident with dates closer to the Monitoring visit having a higher priority. The sample of 10 Restraint Packets contained multiple problems, which provided an opportunity to evaluate the systemic responses to the correction and remediation of difficult circumstances.

Special attention was given to the reason for the restraint (Paragraph 41), the use of the IIP (Paragraph 41b), the use of CPM techniques (Paragraph 42b), the nature and extent of documentation (Paragraph 42c), the use of Documented Instruction (DI) as a teaching and coaching tool (Paragraph 42e), and the nature and extent of supervision of staff (Paragraph 44g). The Restraint Packets normally provide the PH Monitor with the documentation surrounding the physical restraint and the necessary video to substantiate the written documentation.

The review of the Central Services Unit (CSU) Restraint Log regarding use of force raw data between December 1, 2014 and April 20, 2015, identified one (1) unauthorized restraints (Paragraph 41), 22 uses of handcuffs during a restraint (Paragraph 41a), and 27 indications of injury to youth during the restraint (Paragraphs 42f and 44c). If current practices and the facility population remain the same, these data categories project annualized totals of 3 unauthorized uses of force, 57 uses of handcuffs during a physical restraint, 70 injuries to youth during the restraint. The same data project 746 physical restraints annually. OCFS points out that some use of force is necessary with this population of youth, and there may be some truth in this position; however, justifying annualized uses of force at this level seems to question the effectiveness of the intervention.

Two questions remained part of the assessment process. First, did the documentation describe a restraint event that was consistent with the policy, procedure, and practice required by the Settlement Agreement? Second, did the video affirm and corroborate the descriptions of the uses of force contained in the documentation? Nine (9) of the Taberg Use of Force Packets provided to the PH Monitor contained the documentation surrounding the physical restraint and the necessary video to answer these questions.

An action plan requested by QAI in the previous QAI Report called for a review and revision of the previous plan in order to use the administrative review to indicate areas of deficiency as well as areas where there are discrepancies between videos and written documentation. QAI requested this plan to address multiple restraints documented as one incident. Because there was no response to this request, a data audit similar to the one conducted at FLRC needs to occur at Taberg.

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.

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 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.

The PH Monitor reviewed 10 Restraint Packets of youth who were housed at Taberg between December 5, 2014 and March 30, 2015. The justifications listed in the documentation for initiating the use of force in all 10 Restraint Packets was for the "safety of any person" (Paragraph 41i). Of these, five packets were inconclusive because the restraint occurred off camera in the youth's room, leaving five restraint packets for consideration. One of these restraints (312620) was not justified on a safety rationale because the YDA initiated an unauthorized technique without sufficient provocation. Four (4) of the Restraint Packets were justified as the youth created an imminent threat to safety. So, 80% or a preponderance met the justification requirement.

Further, the State shall:

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred. Of the 10 previously mentioned Restraint Packets, the average amount of time "necessary to stabilize the situation" through the application of force was 9.9 minutes. Yet, more precarious durations continue to exist. In the QAI Report Youth 1 experienced a standing restraint of 52 minutes and a "to-the-floor" restraint of 53 minutes, while Youth 2 experienced a "to-the-floor" restraint of 35 minutes. Additionally, handcuffs were used to supplement staff uses of force only once, but the application of

mechanical restraints lasted 29 minutes. While these activities may be consistent with OCFS policy and procedure, they reflect a practice that should prompt reconsideration by OCFS of "only the minimum amount of physical control and time in restraints necessary." Also, see above (page 10) the discussion of uses of mechanical restraints based on information in the CSU restraint log.

The duration or time in "to-the-floor" restraints and mechanical restraints remains an obstacle to compliance. Those who have administered physical restraints to adolescents describe a cycle of struggling that occurs during the restraint. The PH Monitor raised this issue in the December 2014 Taberg Report from his direct observation of the restraint of Youth TC. Report stated:

> Similarly, there was no "additional action required" that could have addressed the pattern of Youth TC's cyclical behavior of moving from agitation to calm to agitation during the restraint. There should be a follow-up discussion about when staff might consider initiating the release procedures during one of the calm cycles. A Home Office observer commented on the pattern, which repeated itself about three (3) times, wondering if bypassing a verbal commitment from Youth TC to calm down might have hastened the release process and shortened the restraint event.

The Taberg GRS shows an increased use of force, but the OCFS data also indicate an increase in the amount of force as measured by the use of handcuffs because of the intensity and duration of a youth's struggles during the restraint. By policy, mechanical restraints are applied when the youth's behavior is out-of-control, and they are to be removed when the youth's behavior is or returns to an acceptable level of safety. Here is where a careful analysis of these alleged cyclical restraint behaviors could be productive. In addition to the increased uses of physical restraints and mechanical restraints, the amount of time a youth is "out-of-control" as measured by the length of time in handcuffs remain at a precarious level.

The PH Monitor raises another question based on an interpretation of the QAI Report on page 95: Is the increase in the frequency and duration of mechanical restraints a substitute for a prohibition against supine restraints in the IIP? This needs further investigation as the Home Office response focuses on the use of mechanical restraints in situations where the youth's behaviors while in a restraint as opposed to her "no-supine" status as the reason for administering mechanical restraints.

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. While 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, an insufficient coherence exists between the IIP recommendations and YDA assessments of their effectiveness.

The IIP is an OCFS-generated treatment resource to help staff reduce the risk of use of force harm by identifying for other staff individual risk factors for each youth and delineating safety strategies to de-escalate emotional dysregulation sufficiently to avoid use of force. 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. 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. An unreasonable expectation would be an absolute adherence to the IIP, but expecting more parallels between the IIP and staff behaviors is reasonable; and examples have existed during monitoring visits where staff were effective at the prescribed de-escalations.

Of the 10 previously mentioned Restraint Packets, only four (4) (40%) contained documentation that staff used de-escalation strategies listed in the youth's IIP. Of these uses, only one (25%) was evaluated as effective in the documentation, which translates to a 10% effectiveness of the IIP as related to use of force prevention. It is understood that this sample of the Restraint Packets represents some of the most challenging situations for staff regarding use of force; but this also underscores the continued disconnect between what the collective wisdom of the support team recommends as strategies for helping youth reestablish emotional regulation and the difficulty of effectuating emotional calming during a crisis situation even though the youth is part of the team generating the strategies. Surely, no agency chooses to argue that the outcomes of these five to-the-floor multiple-staff-member-restraints are without "psychological harm" to this population of girls, so the effectiveness of the IIP as a de-escalation tool must increase.

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 Use of Force Packets, combines with direct observations, youth and staff interviews, and the conclusions

from the Taberg QAI Report 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. Isolated instances (Restraint Packet 656307) continue to occur as a result of unusual circumstances or concerns about individual staff members, but these are mostly technical failures or accidental circumstances and do not represent systematic problems.

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

COMPLIANCE

COMMENT: Taberg has sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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

COMPLIANCE

COMMENT: Taberg has sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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 PENDING

COMMENT: The Monitors requested action by the OCFS Medical Director regarding possible health and sanitation modifications to the YDA staff training based on the multiple incidents where Taberg youth introduced bodily fluids and excrements into the physical restraint process.

Home Office created the Procedures for Dealing with Blood and Other Bodily Fluids Question and Answer document and informed the Monitors of its distribution to all staff in March of 2015, along with instructions to include it in annual Blood Borne Pathogens and Exposure Control Plans training at the facilities. Home Office will also requested this to be reviewed as part of the Blood Borne Pathogens training provided to all incoming YDAs during BAT (Basic Academy Training). This will begin with the next class. Compliance is pending review of policy and the new staff training lesson plan.

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 compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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.

The GRS parallels the latest, best peer-reviewed statement of generally accepted professional standards for quality assurance as described in the recent joint publication of the National Institute of Corrections (NIC), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the National Partnership for Juvenile Services (NPJS). Dedel[1] describes quality assurance elements and strategies that include key concepts of performance-based assessments of policy and procedure using clear performance ratings, identifying underlying causes using data, changing the causes through measured outcomes, assessing effectiveness related to the measurement of the size and scope of change, and the construction of at least three levels of program quality. Her recommended three levels include first a level for exceptional, a middle level for satisfactory or in need of minor improvements, and a third level or *in need for substantial or major improvements*. (emphasis added) The parallels to the green, yellow, and red levels of GRS seem obvious. One implication of the February 2015 agreement on the GRS is that the capacity of the GRS system as demonstrated at Finger Lakes can be used as a reliable mechanism to identify both problems and solutions. The Monitors can now define these "accompanying practices" that exceed the least amount of force necessary for safety by using an important indicator.

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

PARTIAL COMPLIANCE

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

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[1] Dedel, K. (2014). Quality Assurance (Chapter 17). In *Desktop Guide to Quality Practice for Working with Youth in Confinement.* Lexington, KY: National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Download: http://www.desktopguide.info/?q=node/5.

the policy, procedures, training, and evidence of a corresponding practice exist, the quality of documentation has diminished.

All of the crisis management QAI standards were found in some level of noncompliance largely due to documentation deficits. There were multiple instances where the enhanced supervision status was not documented in the CSU, unit, and/or special watch logbooks. Suicide Watch (SW) and/or Personal Safety Watch (PSW) did not have corresponding documentation to show the clinicians were promptly notified, staff used caring techniques, the youth were reassessed during and prior to removal from status, or that crisis management plans were developed. Even with all of the Personal Safety Watch precautions, one youth from Amethyst engaged in suicidal behavior in the bathroom of the Annex on March 12, 2015. Accounts by two staff members described the danger of the situation as graver than what appeared in the documentation in RIR F150651.

The across-the-board reduction in documentation quality signifies supervision and accountability problems by administration, which has been a Home Office concern and resulted in special technical assistance from staff at Industry to suggest ways to improve these behaviors by staff. The QAI Report (page 106) quoted one staff member as responding to Documented Instruction with "It's a good concept but people do the wrong thing over and over, and there are no repercussions. Administration needs to know the difference between a training need and a bad attitude." So, do YDA errors of omission and commission occur because the FD does not know how to provide supervision (as the new Facility Manager reports assert) or because the FD is overwhelmed by the lack of staff and cannot supervise adequately (as implied by QAI) or does the immediacy of multiple ongoing crises cause the FD to take action, even though it would be better in the long run if crisis de-escalation occurred at the YC or YDA level (as recommended by Home Office technical assistance)?

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 is quite extensive and thorough, even though errors and problems persist.

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

PARTIAL COMPLIANCE

COMMENT: The GRS provides important information for compliance determinations for this paragraph. The Therapeutic Intervention Committee (TIC), in conjunction with the administrative review of restraint packets, is the "review by senior management." The TIC has two components, the Home Office TIC and the facility TIC. At the Home Office TIC, a team of OCFS senior leadership staff from the relevant departmental disciplines assembles to address, evaluate, and modify the response plan. The facility 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, these TICs are the mechanism tied to the OCFS restraint metrics by which GRS "red zone" status moves to "yellow" or "green" status.

The Monitors observed a monthly TIC meeting. FD Tulino conducted excellent reviews of physical restraint videos, noting and explaining critical supervisory techniques for YDA staff. Her understanding of the use of force review process underscored the frequent discrepancies between her educational TIC presentation and some of the less than satisfactory VRFs. The perspectives of other reliable sources indicated that the quality of her VRFs suffer not so much from a lack of knowledge about effective de-escalation and minimization of uses of force but from a lack of time to do a competent review. Dr. Tomassone, in a separate meeting the following day, provided an excellent analysis of use of force that laid the groundwork for some special insights about restraint rates. He also tied various treatment issues of particular girls to specific restraint rates and events. This type of analysis could prove to be extremely beneficial to inform staff about new ways to reduce uses of force.

Table 2 charts the 2014-15 uses of restraints. The results are not yet acceptable. At no time is the GRS "red zone" status moved to "yellow" in fewer than 90 days; Taberg spent 10 of 12 months in 2014-15 in GRS "red zone" status; and six months (half the year) of these GRS "red zone" determinations were at a level two time greater that the GRS "red zone" threshold.

Table 2. 2014-15 Graduated Response System Data

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Ave.
Care days per month	592	665	625	631	738	720	707	662	644	552	490	524	629
Total Number of Unique Standing/Escort:	23	41	21	15	36	34	28	31	40	23	5	28	27.08
Standing/Escort Rate Per 100 Days	3.89	6.17	3.36	2.38	4.88	4.72	3.96	4.68	6.21	4.17	1.02	5.34	4.23
Total Number of Unique Ground/Restraint:	21	31	25	16	40	29	40	43	64	39	14	39	33.42
Unique Ground/Restraint Rate Per 100 Days	3.55	4.66	4.00	2.54	5.42	4.03	5.66	6.50	9.94	7.07	2.86	7.44	5.30
Technique Not Sanctioned Rate Per 100 Days	1	0	0	0	0	0	3	1	3	0	0	1	0.75
Total Unique Restraints	0.17	0.00	0.00	0.00	0.00	0.00	0.42	0.15	0.47	0.00	0.00	0.19	0.12
GRS Zone	7.43	10.3	7.36	4.91	10.30	8.75	9.62	11.18	16.5	11.3	3.88	12.79	9.54

The implications about the inability to move the GRS into the "yellow" or "green" zones become increasingly important in conjunction with the earlier references to the CSU Restraint Log data regarding uses of unauthorized restraints, handcuffs during a restraint, and injury to youth during the restraint.

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.

The selection of Restraint Packets includes situations and restraints that involve complex and challenging situations to assess how well staff respond to the most difficult circumstances. Implicit in these assessments is the assumption that staff will make mistakes or will do things incorrectly but even the proper application of CPM may result in unwanted outcomes. Therefore, an important element of compliance is an effective system for corrective actions. OCFS has made great use of DI and coaching as methods to correct and improve staff skills.

Of the 10 Restraint Packets in this "Red Flag" Restraint Review, all 10 (Packets 325796, 293647, 334037, 334037, 286506, 312620, 312620, 290387, 308537, 269301) contained video evidence of staff behavior that warranted DI or coaching, but only three packets contained a request for DI and one of the three was prompted during the QAI review. There was no way to identify characteristics of the restraint event prior to selecting the Restraint Packets, so the presence of five in-room restraints out of a sample of 10 restraints raises a red flag about possible changes in use of force practices due to increases in Suicide Watches (SW), Personal Safety Watches (PSW), and Arm's-Length-Supervision (ALS). In-room restraints are problematic because they are off-camera and, as noted above, there is no way to independently verify the accuracy of the justification for restraints as listed in the documentation. As a result, Home Office needs to consider a strategic plan to address in-room restraints. Until that occurs, a discussion with a trainer or supervisor through the DI process should occur at a minimum and should also include a critical incident review on how staff can better help themselves and youth by remaining on camera. Granted, this is problematic if the restraint occurs, as Tomassone noted, because the youth is actively engaged in a suicidal gesture in her room that requires staff to remove a dangerous item. Nonetheless, greater thought needs to be given to this type of use of force.

Deficits continue to exist in staff members' ability to use CPM techniques correctly. Of the 10 Restraint Packets in this "Red Flag" Restraint Review, four Restraint Packets (269301, 286506, 290387, and 312620) contain evidence of improper or inappropriate or unauthorized CPM techniques. Additionally, Restraint Packet 312620 contains documentation to suggest a gender-bias regarding restraint.

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.

SUBSTANTIAL COMPLIANCE

COMMENT: Taberg has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

C. Emergency Response

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 achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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

COMPLIANCE

COMMENT: Taberg complies with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets and the Restraint Log from CSU, combines with the Special Incident data from Home Office 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: Taberg has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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

COMPLIANCE

COMMENT: Taberg has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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. 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 compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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 of 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 clinic remains a Protection from Harm strength. Reviews of Post Restraint Examinations (PRE) were complete and comprehensive, and the number of restraint events noted in the CSU Restraint Log corresponded to the number of PREs. The procedures for the Post Restraint Examination remain the same.

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: Taberg has sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Taberg QAI Report support this finding.

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

PARTIAL COMPLIANCE

COMMENT: The level of disruption has had an adverse effect on staff supervision due to the small size of the facility in the absence of staffing adequacy. Uses of DI, coaching, and supervisory follow-up must return to acceptable levels similar to those experienced by staff at the end of 2013 in order for supervision of staff to be consistent with generally accepted professional practices. For example, the Taberg identification of issues needing DI is 20%. The difficulty in making recommendations about compliance thresholds or specifying necessary improvements is greatly compounded by the lack of staffing adequacy and the lack of continuity in the VRFs.

Another side effect of understaffing is the accurate completion of the Restraint Monitor function. Only 61% of restraint packets met the QAI standards for Restraint Monitoring. The most disturbing finding from QAI was related to Restraint Monitors not being present for the restraint. The Restraint Monitor standards are Home Office-generated and Monitor-endorsed safeguards instituted to ensure oversight of the new and difficult to implement CPM so that the safety of youth and staff is insured. It is the Restraint Monitor that is the gatekeeper to DI and coaching by providing information to the administrator doing the Video Review Form.

Beyond YDA and YC/AOD supervision, the PH Monitor alerted Home Office through comments in the previous monitoring report that the September 2014 change in Taberg's Facility Manager had resulted a discernible change in the content and tone of the Facility Manager Reports, particularly the elimination of references to the previously cited problems of getting the Facility Director adequate resources consistent with the assessment of the Home Office technical assistance provider and prior monitoring reports. In advance of this monitoring visit, all of the new Facility Manager's reports were requested and reviewed. Additionally, another Home Office staff member affirmed the PH Monitor's observation about the change in content and tone of the supervision of the FD. Multiple staff made unsolicited comments about their dislike for what they perceived to be the changes in the nature of the supervision of the FD. The perceptions of these staff was that Home Office refused to address and correct the problems of another administrative staff while behaving as if it wanted a change at the FD level, and this proved unsettling and did not build confidence within the staff who believed they too would not be treated fairly by Home Office. During the monitoring visit, the PH Monitor stated to the Facility Manager that an independent review and comparison of a year's worth of Facility Manager reports would likely conclude that there had been a clear shift in the nature and tone in the supervision of the Taberg FD, so much so as to create the impression that the Facility Manager was building a case to remove the FD. A review of these findings with the Settlement Coordinator prompted him to secure an immediate commitment from Home Office to take quick remedial actions to support and develop further the Taberg FD. Following the monitoring visit, the Taberg FD submitted her resignation; her last day at Taberg was May 15, 2015. The handling of this key leadership position further aggravated the aforementioned concerns about staffing transitions.

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

Despite continuing problems with hiring and retention, Taberg staff persist in implementing the New York Model. Addressing a complex variety of mental health and developmental needs is a continuing challenge in a facility that is the only limited secure program for girls and has the only mental health unit for girls in the state. Most of the girls on both units have challenging behavior driven by trauma and many do not have a re-entry placement likely to provide permanency and adequate support to continue the progress they make at Taberg.

The lower population (from 24 in December, 2014 to 17 at this site visit) resulted in smaller, less stressful units and clinicians and YCs having more time for each girl. However, the population was increasing with four new admissions immediately after the site visit. It is almost impossible to have sufficient trained staff to provide the 1:1 attention and

support for self-calming necessary in a unit of 10 or more girls who constantly trigger each other.

Although Taberg expected to have its full clinical team for the first time soon after hiring the Assistant Director for Treatment in the fall, 2014, a clinician left following the last site visit. The Assistant Director for Treatment and the new substance abuse clinician left shortly after this site visit. At the time of this visit, the two clinicians and one substance abuse clinician were working long hours to achieve the required minimum once weekly individual therapy (and more for many residents) for these challenging, high needs girls.

The clinicians have continued to support staff in providing more 1:1 attention for girls before they reach crises in order to help girls learn to regulate their emotions. The use of "Code Grey" to indicate that a girl is escalating, and the clinicians' responsiveness by arriving immediately and helping her calm herself has been effective. Both are demanding on staff and cannot be maintained without fewer residents or more YDAs, YCs and clinicians.

The shortage of YCs and the lack of an Assistant Director for Program also remain serious problems at Taberg. A new YC had just been hired and another new YC had returned from the Academy in time to assume the caseload of a YC going on paternity leave. It was hoped that by June, 2015, each unit would have two YCs. However, one YC on each unit is also designated as AOD. Taberg is budgeted for six YCs and an additional YC for the new Facility Security Administrator function, so even fully staffed there would not be a YC unit manager and a YC coach/case manager on each unit plus full AOD coverage for the facility. Staff from Industry were assisting Taberg in implementing a "tracking model" they found effective for breaking the units into smaller groups for activities, but that approach would also benefit from having two YCs on the unit (neither functioning as AOD).

The QAI Review at Taberg (April, 2015) commented that "Taberg has been operating without an Assistant Director for Program since October 2014. The facility is budgeted for seven YC-1 positions (this includes one item which was temporarily re-assigned to Taberg from another facility); they currently have five filled, but report only having three available. Taberg needs to hire two more clinicians to complete the team."

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 remain the shortage of clinicians and YCs and the large number of extremely high-needs girls requiring intensive support.

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 (revised, May 2015) 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, and groups were observed in the QAI review.

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.

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

COMPLIANCE

The New York Model, BBHS procedures and OCFS Psychiatry Manual 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 and comply with 46c. 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 PH Monitor and MH Monitor observed the Taberg TIC attended by almost 30 staff, including YDAs, YCs, clinicians, teachers, nurse, cook, and trainer. A YC reported on restraint data from one unit and the Director led applause for staff keeping restraints down. Two girls have been involved in many restraints, and staff shared ideas for how to de-escalate them more effectively. It was announced that the DBT consultants are helping

with a self-esteem improvement effort by designing posters with residents' pictures being produced on the Taberg printing press. A YDA and the Director led a productive discussion of a video of a situation between two residents. In observing another video from the previous day in which a resident had been moved to the library to cool off and pulled hundreds of books off the shelves, staff were commended for how they managed her escalation. A clinician provided detailed guidance for how to support three girls who have had increasing restraints: one is developmentally delayed and "gets startled and escalates rapidly. Intervene quickly. Get her to a trusted staff person ASAP. Be patient." The Taberg TIC was described by participants as team-building. For example, "by getting the teachers' perspective, it shows that YDAs are supporting them." Discussion of videos were described by staff as an especially valuable part of the TIC.

Meeting notes from the Taberg TIC in previous months showed discussions about progress made and improvements necessary in the program. In January, 2015, the TIC recognized that restraints were decreasing. It was announced that two new YCs had been selected and the substance abuse clinician would soon begin. Clinicians and YDAs were in DBT training, with teachers scheduled for DBT training soon. In February, 2015, the TIC recognized staff for their skills in de-escalation and relationship-building with residents, resulting in a decrease in restraints. High restraint rates during the 3-11 PM shift were discussed. Revisions to the DAS sheets were discussed. The new substance abuse clinician was welcomed, and another clinician left. YDAs were recognized for providing extra support in the classroom. The clinicians shared ideas about residents. In March, 2015, the TIC commended the decline in restraints.

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

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") are consistent with the New York Model and comply with 46d.

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

On Site Observations Regarding Paragraph 46a-d (April, 2015)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS does not have to implement the New York Model to comply with Paragraph 46, but OCFS is choosing to comply with Paragraph 46 with the New York Model.

The New York Model has been implemented at Taberg. Integrated assessments and support plans continue to improve. Support teams are excellent, although they seldom include YDAs. The Daily Achievement System (DAS) and phase system are in place. 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 the Taberg Mental Health Rounds in which all the girls in the facility were discussed, with the clinician presenting a current report about each. The purpose of the meeting appeared to be to update the psychiatrist, clinicians, and YCs. There was little discussion of diagnosis or symptoms being treated with psychiatric medicines. For one girl ideas were shared about how to help her "connect past trauma to her current issues and the whole team working on how to support her in learning how to have trusting relationships." The romantic relationship between two girls, "both acting out their trauma" led to a lively exchange between their clinicians about how to keep both residents safe. The unit team reported they were meeting twice weekly to assess the progress of another girl who was being managed in a separate program due to her behavior. Unfortunately, only one YC and no YDAs attended Mental Health Rounds, so clinicians must convey the observations to the unit teams.

Because of staffing problems, Taberg is missing one of the primary benefits of the original design of Mental Health Rounds and support teams: that YDAs can make a unique contribution with their observations and can learn from the perspectives of the psychiatrist, clinicians and YCs as they share their views of a resident.

The MH Monitor observed a strong intact team meeting with 10 YDAs, 3 clinicians, 3 teachers, a nurse, two YCs and the Assistant Director for Treatment reviewing all ten girls on the unit. They passed around the girls' current IIPs. The dramatic reduction of restraints on the unit was commented on, and restraint data (which, it was noted, showed no peak in restraints in any day of the week or shift in contrast to the other unit), was circulated. The clinicians provided helpful guidance about how to support each girl, and particularly recognized the efforts of staff to individualize treatment for a developmentally delayed girl as well as a girl with high anxiety about her imminent departure and a girl still struggling with being controlling in relationships. One YDA commented helpfully—"Beware, if you're redirecting another resident, [redacted] has to jump into it." Another YDA added, "[redacted] and [redacted] have to be kept apart." Sharing these observations helps all staff be proactive and ensure two staff intervene together with these residents.

The MH Monitor observed an innovative DBT group led by a clinician: the six girls each had their body traced on huge pieces of paper and were writing feelings on the parts of their bodies where they feel them. They were very involved in the project, and it was impressive how complicated their feelings were. One resident used a different color for each feeling, and said she often had mixed feelings so she wrapped the two colors around each other. Guilt, fear, and loneliness were common themes in the drawings. The clinician had been looking for a way to get the girls involved in DBT because they did not enjoy the didactic sessions. They will be able to hang their drawings on the wall for individual therapy and support team meetings and use them to talk about how to tolerate the distress they have written on their body outlines.

Ms. Rivera-Barrett commented about another skillfully-run DBT group by the other Taberg clinician: "The majority of the group were engaged in the conversation while two

youths made every effort to be disruptive. In true DBT fashion [the clinician] did not allow the inappropriate comments of the two girls to divert his attention...he capitalized on their behaviors as he used their comments as teachable moments. At no point did he allow himself to get rattled. He maintained his composure and continued to deliver his discussion in a pleasant enthusiastic manner…I felt those girls should have been removed from group as they were such a distraction, however after talking with the unit staff and the Director, they know their girls and knew what they were doing by not addressing them. In the spirit of shaping behavior the staff deliberately didn't give them attention as it would be reinforcing to them, and would cause them to further escalate the situation."

The QAI Review (April, 2015) at Taberg commended the observed support team meetings for being "strength-based and trauma focused. Each team member present had a role and participated. There was a tremendous amount of encouragement and recognition for the changes and progress the youth had made. Problem behaviors were spoken about in an objective manner without judgment."

During this site visit, Dr. Tomassone presented on Taberg's Treatment Environment, examining the connections among restraint rate, false sexual allegations, suicide RIRs and intakes (especially returnees) on a Taberg timeline of October, 2013-March, 2015. Analyses of intake, abuse allegations, restraints, and suicide RIRs per 100 care days found that suicide RIRs and restraints are highly correlated at Taberg. In March, four girls accounted for 40 out of 68 restraints and these girls also had multiple suicide RIRs. Fortunately there were no serious suicide attempts (no trips to the emergency room), but there was a high number of incidents of talking about suicide. Suicide RIRs were seen as too inclusive—they include both gestures and comments. Although there was no analysis of diagnosis, symptoms, or psychiatric medicine, suicidal talk was viewed as communication in girls most of whom do not appear depressed. If girls see the benefit of suicidal talk as getting more individual attention, suicide RIRs could increase. Many restraints occurred when staff intervened to remove a dangerous item (e.g., an article of clothing or sharp object) from a girl threatening to hurt herself: in January, 89% of restraints were for this purpose; February 75% and March 78%. The question was asked, "What other interventions with a suicidal girl can keep her safe without leading to a restraint?" This was crucial information that would have been beneficial to present at the TIC the previous day. Hopefully clear ideas for alternative interventions with suicidal girls will be developed, presented at intact teams and the next TIC, and practiced. If suicidal talk is a way of communicating, staff can improve in pre-emptively meeting needs. More detailed discussion of how to build staff de-escalation skills for residents in crisis and how to support them in intervening early is necessary, including pursuing the idea presented at the meeting that before a crisis residents must be guided to use their self-calming skills. The latest interventions at Taberg were described as: (1) DBT Consultation on Suicide RIRs (discussion of para-suicidal behavior and secondary gain); (2) Teamwork of staff and clinicians to effectively and safely respond to youth behaviors and meet youth needs; and (3) Consultation and training from the Industry Director, NY Model coach, Recreation Specialist, and YC (in implementing unit tracking to break youth into groups of 5-6 for increased focus on mentoring and YC counseling). The presentation also included the importance of the dynamics of returning residents. It was pointed out that return to Taberg should occur only when there are no other ways to maintain youth or community

safety. Approaches proposed for expanding options for release for Taberg residents included: increasing RTF beds by 8; an internal Hard to Place Committee (the Associate Commissioner for Community Services and BBHS) with home office release monitoring (discussing specific youth, current resources, and needed resources); RTF expansion; and ongoing recruitment efforts for all staff positions including attempting to certify Taberg as a National Health Service Corps site to allow repayment of student loans.

Five of the 17 Taberg girls at the time of the site visit were returnees: CP (age 14, arrived 2/24/14, left 2/23/15, returned 3/24/15), SP (age 14, arrived 10/18/12, left 12/10/13, returned 12/3/14), JR (age 14, arrived 1/23/14, left 10/7/14, returned 2/19/15), MM (age 15, arrived 3/13/14, left 8/21/14, returned 4/1/15), and FS (age 17, arrived 8/22/14, left 11/6/14, returned 4/2/15). Two of the four admissions the day after the site visit were returnees, bringing the total to 35% returnees in the population.

One returnee who was a developmentally delayed 12-year old when she was inappropriately placed at Taberg in 2012 had made tremendous progress with special interventions by staff over 14 months and had been successful in foster care for a year before the placement disrupted, apparently due to insufficiently intensive home-based services to support her and her foster parent. Taberg discharge planning for another returnee to residential treatment had been done with meticulous care: before leaving, she visited the residential program and "made initial contact with both her case manager and clinician. She reported feeling comfortable with them and was able to discuss some of her unique treatment needs such as a need for individual therapy more than once weekly. The treatment team discussed her history of complex trauma. She visited the educational program and was excited about the "resources" available to her. She met with the school counselor and a teacher. She was able to identify needing more support with math and science and reported wanting to work on decreasing behavioral outbursts in order to better attend to her school needs. She was excited about participating in arts/craft programs, pottery, water sports, and the horticulture program. She talked to her social worker about her substance abuse needs and will attend weekly substance abuse groups to create a relapse prevention plan and prepare for her discharge into the community. She discussed her fears of returning to the care of her mother given recent allegations of sexual and physical abuse against her mother. Clinicians and other staff in the meeting told her she is going to be a driving force in her long-term discharge planning. She expressed wanting to have regular contact with her younger siblings and will be offered supervised contacts in addition to family therapy." Nevertheless, a month later she returned to Taberg.

It is difficult for residents to return to a facility. They arrive with feelings about what precipitated their return (including anger about how they feel they were treated) and are often ashamed that they were not successful in the community. Some may be relieved to return to the comfort of their relationships at Taberg but may not want to acknowledge their dependency. They may believe they have completed the program and may not want to start over; they may feel hopeless and not want to set new goals or resume their work on skill-building. The returnees are discouraging for staff who put so much effort into the resident's progress at Taberg and planning for success in the community. Anticipating the effects of a returnee on a unit and the work it will take to arrange another placement is stressful.

Interviewed staff had two hypotheses about why so many girls return to Taberg, after making so much progress before leaving. Many are unable to make a successful transition to their next placement despite the efforts of Taberg staff and CMSO in arranging re-entry services. Sufficiently intensive services comparable to what Taberg offers are not available for girls in step-down placements and in difficult home situations. Despite the obvious likelihood of regression when they lose their Taberg relationships, the urgency of providing more support than the girl required at the end of her Taberg stay does not seem to be part of the stepdown and B2H approaches. Secondly, some girls said that they purposely acted out to be returned to Taberg. It is a real breakthrough that they may have had their first trusting relationships at Taberg, and more effort to establish trusting relationships in their next placement before leaving Taberg are necessary.

Several efforts could reduce the number of returnees to Taberg: (1) preventing the placement of children who require intensive services in the community at Taberg in the first place (it is predictable that developmentally delayed and traumatized residents would form trusting relationships at Taberg that they would have difficulty replacing); (2) working with step-down residential and foster care programs that might be placements for Taberg residents to insure that they have sufficiently intensive, relationship-based, trauma-responsive services to continue girls' progress; and (3) her team developing a specific return-to-Taberg-prevention-plan with a resident, her CMSO and stepdown placement before discharge (making sure that her new staff understand what triggers the girl, how to help her de-escalate to avoid situations where her disregulation could lead to an incident that will get her removed from the program; a return prevention plan should define situations likely for this girl in the first months of the new program as she is slowly building trust when she will have difficulty with distress tolerance, and what she and staff can do).

Hopefully, efforts such as these will reduce the rate of returnees to Taberg. If a girl returns, her new support plan should reflect specifically what it will take for her to be successful in her subsequent re-entry. The reasons her gains prior to release had not continued in the community must be specified in each returnees' support plan. For example, [redacted] current support plan did not mention her stay at Taberg 1/14-10/14, release to a stepdown 10/14-2/15, and her return to Taberg in 2/15, or the lessons to be learned for her next re-entry. Her progress was noted, but what will sustain it if she returns to her mother's home is not apparent: "She has been able to identify that conflicts with her mother were most often the reason for her decisions to leave home, use marijuana, and engage in dangerous sexual behaviors. She was insightful in being able to identify relational and trauma related triggers leading to her dangerous behaviors leading to her OCFS placement."

In addition to the challenges presented by returnees, inappropriate placements continue to reduce Taberg's effectiveness. Staff spend many hours providing extra support for residents who are not typical delinquents, but due to trauma-related behaviors were sent to RTCs where their needs were not met and their reactivity in the program led to their placement at Taberg. The systemic response to these girls should instead be to intensify services at a residential program specifically designed to treat trauma.

[redacted] a 15-year old who arrived at Taberg in March, 2015, is an example of a high-needs resident who is not a typical delinquent and should not have been placed at Taberg.

Committed to DSS, she was determined developmentally disabled and eligible for OPWDD services; appropriate placement should have occurred through DSS and OPWDD. She was psychiatrically hospitalized at least seven times between 2007-2014. Several Taberg staff commented that she functions like a 5-year old, throwing herself on the floor in temper tantrums when someone says "No" or she does not want to move to a new activity. The Taberg Director gave [redacted] a doll to take care of, and coloring is another activity she enjoys. Her Taberg Integrated Assessment noted that [redacted] "struggles in communication and has difficulty with problem solving." Reportedly, DSS asked for OCFS placement because she had been referred to many agencies, including out-of-state, and was rejected "due to her high-risk aggression, requiring higher structure and supervision." Inappropriate placement at Taberg is harmful for [redacted] and requires different staffing than Taberg can offer without compromising treatment for other residents. OCFS noted that the court adjudicated [redacted] and other Taberg residents delinquent and OCFS cannot refuse intakes; furthermore, the voluntary agencies do not accept some youth because of aggressive behavior. DJJOY is continuing to provide training and technical assistance to voluntary agencies so they can provided enhanced services for girls.

The high demands of inappropriate placements and returnees as well as the needs of traumatized delinquents who are first-timers at Taberg require extraordinary teamwork among YDAs, YCs, clinicians, and other staff. The coaching team described trusting relationships between YDAs and clinicians/YCs that have resulted in opportunities for guiding the practices of YDAs, most of whom have been at Taberg less than three years. The priority goal of coaching is to make sure all staff are aware of reinforcing skillful behavior and beware of secondary gain for girls from staff mistakenly reinforcing negative behavior. As coaches discussed, "The best way to make DBT skills digestible to kids is immediately reinforcing when staff see a skill being used." When residents learn to take responsibility for their behavior, they will proudly express "I used a skill, I did it purposely." Teaching everyone how to get ahead of residents' feelings and behaviors instead of being reactive remains an important coaching goal. Since the last site visit, clinicians and YCs have worked hard to help residents change their perspective, and, as a result, "I have to misbehave to get attention" was not as frequently voiced by residents in this site visit.

Until all the clinical and YC positions are filled, it will be difficult for Taberg to comply with paragraph 46. The allocation of positions for clinicians, YCs and an Assistant Director for Treatment may not be sufficient for the size and complexity of the Taberg population. Each clinician has high needs residents, plus residents on medication involving meeting with the psychiatrist, plus new residents requiring Integrated Assessments, plus residents requiring considerable work to arrange re-entry services. These are all time-consuming clinical responsibilities in addition to individual therapy (once weekly for most residents), group therapy, family work, support teams, special watch evaluations, and JJIS documentation. For all staff to collaborate on supporting residents to develop distress tolerance and emotional regulation so they can be successful in re-entry requires clinicians who not only have the time to provide individual, group and crisis treatment but also to coach staff to effectively utilize DBT and Sanctuary skills.

During 3/1/15-3/31/15, one clinician saw seven residents in individual therapy, four four times, one five times, one seven times and one eight times. A second clinician saw seven residents in individual therapy, one once, two four times, three eight times and one nine times. A third clinician saw seven residents in individual therapy, one once, two twice, one six times, one seven times, one eight times, and one nine times.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Taberg records; support plans indicated the IIP has been reviewed. IIPs were reviewed at the observed support team meetings and intact team meeting. Taberg clinicians are preparing exemplary IIPs that are instructive for all staff. For example, "She is effectively using journaling. Remind her to journal." For another resident: "Provide undivided attention—sitting next to her. Until she builds more trust, asking questions can feel intrusive to her, but she appreciates presence."

The MH Monitor observed an effective pre-shift briefing led by the AOD involving numerous Taberg staff. Taberg uses this briefing as an opportunity for coaching by reminding staff how to model and support the girls in using skills to tolerate distress and regulate their emotions.

The MH Monitor reviewed the DAS sheets of one resident ([redacted] a 17-year old who had been at Taberg for more than four months. She had the highest number of restraints in the previous month and also several suicide watches. [redacted] has a long history in foster care, after her addicted [redacted] disappeared and she was placed at age 5 with her [redacted] and subsequently with her [redacted] where she was abused and neglected and placed in foster care when she was 10. She returned to her [redacted] as a teenager but [redacted] was unable to care for her, and she was placed in RTC with four psychiatric hospitalizations in 2013 and 2014. She was placed at Taberg after cutting another resident in an RTC. Her diagnosis is Mood Disorder and she is prescribed Abilify. In January she had a change in clinicians because her clinician left Taberg; in April she was assigned a new YC. Family contact is important to [redacted] who wants her brother (who was incarcerated) to visit her, and her clinician facilitated phone calls between them. She had individual therapy 4/20, 4/17, 4/16 and 4/15/15 (assessment of ALS), 4/9/15, 4/6/15 (assessment of ALS), 4/3/15 (assessment of SW). On 4/1 she had a Red Flag meeting, and on 4/14 her support team commented that she continued to have trouble engaging in program because she was so easily triggered. The days before the site visit, the DAS reflected that [redacted] had two difficult shifts on both days: 6-10 AM, and 10 AM-2 PM during which she had no achievements due to a code, refusing to engage in class or do schoolwork, being verbally aggressive, not accepting responsibility for her behavior, blaming others. On both days she had B achievement, but it was only totaled on one of the DAS sheets. Despite these behavior challenges, [redacted] is preparing to transfer to RTF.

The MH Monitor reviewed the DAS sheets of [redacted] a 15-year old who had been at Taberg for almost six months. Her childhood was "filled with sexual, verbal and physical abuse." She is working in weekly therapy sessions to connect her childhood trauma to her emotional instability and expressed a desire to have more healthy relationships. She identifies how alcohol and drug use has been an outlet when she wanted to avoid feelings and expressed a desire to stop substance abuse. She was on suicide watch in early April. In the two days before the site visit, the DAS reflected that [redacted] achieved all her achievements

on one day and almost all on the second day, although there were no notes regarding unacceptable behavior; 2-6 pm was not scored and her achievements were not totaled on one of the DAS sheets.

The MH Monitor reviewed the DAS sheets of [redacted] a 14-year old who had been at Taberg for two months. She achieved a level, with all five achievements in every time period; her achievements were not totaled on either of the DAS sheets. She is improving in distress tolerance and interpersonal effectiveness skills and working in therapy on identifying the substance abuse triggers she will encounter upon returning home. Her mother is visiting and her clinician is providing family counseling on Saturdays (although they are refusing B2H when she returns home); her mother encouraged [redacted] to remain at Taberg until she has taken her Regents.

The QAI Review of Taberg (April, 2015) commended its sense of community: "Multiple examples of NY Model, Dialectical Behavior Therapy (DBT), and Sanctuary language were observed by QAI in staff interactions. The staff were heard talking about behavior shaping; specific DBT skills they had tried to use with youth; as well as being more attuned to their co-workers' needs, when in need for time away or some ventilation. The majority of the staff interviewed emphasized the importance of having strong relationships with the youth, and the need to 'Know your kids' to avert/manage crises."

The QAI Review (April, 2015) at Taberg reported that in an observation of Mental Health Rounds "the meeting was driven predominantly by the clinician and the psychiatrist. However, it was a collaborative process and there was an exchange of information between all parties present, when it was relevant. The information shared about each youth was comprehensive and gave the impression that the clinicians were extremely knowledgeable about all of the youth on their caseloads. Additionally, it was evident that the psychiatrist had thorough knowledge about all aspects of each youth's care. This was evidenced by his knowledge about which of the youth were on enhanced supervision status. It was noted in the meeting that a clinician was leaving, and her caseload was going to be divided between the remaining two clinicians. However, the outgoing clinician was not in attendance in this meeting to present her youths' individual therapy goals. The clinicians took turns presenting their entire caseload to the team and then left the meeting. There was no involvement by any direct care staff. This may have been due to a crisis with a youth who had begun hurting herself and had become aggressive with staff during the time that Rounds was going on."

The QAI Review (April, 2015) at Taberg found that although several reviewed residents had individual mental health sessions more than once a week, overall an insufficient number of individual mental health sessions were occurring, and an action plan for improvement was required.

The revision of 3243.33 Behavioral Health Services policy (PPM 3243.33, revised 5/21/15) updated reporting requirements to reflect electronic reporting in the Juvenile Justice Information System (JJIS) and strengthened the requirement for clinicians' family contact: "The youth's assigned clinician will have contact with the youth's family/caregiver/release resource at least twice monthly and will provide the family with psychoeducation as indicated. The clinician will work to engage the family in the treatment

process." The QAI Review (April, 2015) at Taberg found insufficient documentation of the required once/monthly family contacts by clinicians, and an action plan for improvement was required. There was no indication of how much this was a documentation problem, a clinician caseload issue, or the number of Taberg residents who do not have family members to contact.

The QAI Review (April, 2015) at Taberg required an action plan "for training and coaching direct care staff in writing more descriptive log entries which correspond with the DAS sheets. Staff members appear to be routinely documenting youth behavior as 'Good day, no issues'…It is equally uninformative when there is a behavioral issue to simply document 'poor day' as it does not speak to the area in need of improvement nor inform oncoming staff of the area of concern. This is especially problematic when "poor day" corresponds to a 'Y' on the DAS sheets as it then gives the appearance that youth receive the same achievement level regardless of behavior and program participation. Additionally, the plan should include instruction for staff in proper completion of the DAS form…the forms reviewed were not fully completed and the majority did not contain staff signatures or initials…Finally, there were no instances of the sheets being signed by the youth in this review sample. Reviewing the sheets with the resident provides an excellent opportunity to give the youth feedback regarding program and behavioral expectations."

FUTURE MONITORING

It is essential for Taberg to have all clinician and YC positions filled in order to continue to demonstrate compliance with Paragraph 46.

Having sufficient clinicians is essential for every resident to be seen in individual therapy at least once monthly and every resident prescribed psychiatric medicine being seen in individual therapy weekly; given their history of trauma, all residents may require at least weekly trauma treatment. Coaching staff in the integration of DBT and Sanctuary skills on the unit should occur both in individual discussions and by the inclusion of YDAs in Mental Health Rounds and support teams.

Compliance with Paragraph 46 requires consistent program effectiveness that is not compromised by the large number of returnees and inappropriate admissions at Taberg. It is essential that inappropriate admissions of aggressive girls who are not typical delinquents be reduced by intensifying services in residential programs specifically designed to treat trauma. It is essential that the number of returnees be greatly reduced, by stepdown and community programs offering the quality and intensity of services provided by Taberg.

The MH Monitor will observe the facility's use of information to regularly assess the effectiveness of interventions for all residents, with attention to teaching self-calming to residents who escalate quickly, and modifying support plans.

The MH Monitor will observe continued implementation of effective New York Model practices (including improvements in the use of DBT and Sanctuary skills).

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 in OCFS Facilities" (9/15/14) 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)) complies with 47b and indicates that "each of the facilities reports having an established procedure in place." Updates regarding the staff person to be contacted for mental health crises after hours at Taberg are decided at the facility level and are maintained at the Central Services Unit (CSU), which complies with 47b.

47c. Require that any youth who experiences a mental health crisis and resorts to maladaptive coping strategies, such as self-injurious behavior, is referred for mental health services following the resolution of the immediate crisis. A qualified mental health professional shall develop a crisis management plan in conjunction with the youth and his or her other mental health service providers. The crisis management plan shall specify methods to reduce the potential for recurrence through psychiatric treatment, treatment planning, behavioral modification and environmental changes, as well as a strategy to help the youth develop and practice positive coping skills. Such services shall continue throughout the duration of the youth's commitment to the Facility.

COMPLIANCE

The revised PPM 3247.60 "Suicide Risk Reduction and Response in OCFS Facilities" (9/15/14) complies with the requirements of 47c: "From the point of entry into the DJJOY system, throughout all areas of youth programming and extending to the transition back to the community, staff must be continually aware of suicide risk factors and the possibility of adolescent suicide or serious self-harm. Further, when evidence or information arises about the possible suicidal ideation, intent, or behavior of a particular youth, OCFS will respond effectively to maintain the physical safety and emotional well being of the youth. A youth shall remain on enhanced supervision status until a mental health clinician

authorizes modification of the enhanced supervision or removing a youth from special supervision status based on a clinical assessment. Youth on enhanced supervision status will be seen by a mental health clinician to reassess the need for enhanced supervision as frequently as may be indicated by changes in the youth's presentation, whenever possible every 24 hours."

On Site Observations Regarding Paragraph 47a-c (4/15)

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

Taberg had 26 suicide watches between 3/1/15-3/31/15, which is more than twice the average of 11per month during 2014. Between 3/1/15-3/31/15, 11 residents had suicide watches; four of them each had four during the month. Fifteen of the 26 suicide watches were for one day or less, six for 2 days, four for 3 days and one for 4 days. Between 3/1/15-3/31/15, seven residents had personal safety watches; two of them had two personal safety watches in the month. Five of the personal safety watches were for one day or less, two for 2 days, one for 3 days and one for 4 days. Between 3/1/15-3/31/15, 13 residents had arms length supervision; three of them had arms length supervision twice during the month. Six of the arms length supervisions were for one day or less, six for 2 days, two for 4 days, one for 7 days and one on a special program for an unknown number of days. As noted above in the presentation of the Taberg environment, this high rate of special watches is concerning (16 residents at some point in the month were on personal safety watch, or ALS, or Suicide Watch). Completing mental health assessments for suicide almost every day, and then re-evaluating each resident, is a major time commitment for clinical staff.

One Taberg resident went to a psychiatric hospital in the six months before this site visit. [redacted] had several incidents of attempting to harm herself during one week, reporting suicidal thoughts, and hopelessness. She tied her shirt around her neck requiring the cut down tool and immediate medical attention. On 12/5/14 she was taken to the emergency room in Rome, NY. She was hospitalized at Pinefield 12/8-12/12/14. She is a 17-year old resident who had repeated AWOLs from residential programs because she felt staff were antagonizing her, and she was admitted to Taberg after an assault at a program. Her reception diagnosis was Conduct Disorder, Bipolar Disorder, Polysubstance Dependence, Rule Out PTSD; in the past she had been diagnosed with Reactive Attachment Disorder. Her [redacted] died of a drug overdose when she was [redacted] and her [redacted] from whom she was removed at age 8, was depressed and abusive. She started drinking alcohol at age 9 and also used other substances to numb her feelings. She had been in several foster homes, as well as being hospitalized for self-harming behaviors. After she returned to Taberg from the hospital, she continued to be placed on suicide watch, including four times in the month before this site visit. She continued to attack staff, saying that her anger was justified. She was beginning to learn about her confusing internal emotional states. Her goal in her support plan was to transfer to an independent living program, with all staff assisting her in learning to communicate her needs without using suicidal threats and recognizing trauma-related triggers leading to her past choice to use substances. School staff had been taking work to the unit to attempt to engage her, and in the month before the site visit, she finally became interested in enrolling in the TASC (GED) program. Staff have been working

with her and her mother by phone to discuss [redacted] long history of traumatic family problems which have contributed to years of anger at her mother.

The QAI Review at Taberg (April, 2015) concluded that "Overall, the Crisis Management section scored within the Not Meeting Standards. Commonalities among the records that impacted performance were instances of Suicide Watch (SW) and/or Personal Safety Watch (PSW) that did not have corresponding documentation to show that clinicians were promptly notified, staff used calming techniques, the youth were reassessed during and prior to removal from special status, or that crisis management plans were developed. In several instances, the clinician documented a session with the youth around the time the youth was on special watch, but the content of the contact notes did not reference the youth's status. There were multiple instances where the enhanced supervision status was not documented in the CSU, unit, and/or special watch log books. Only a few of the log entries were directly written by clinicians. Multiple youth on enhanced supervision status were often clustered together in one entry with the following statement: 'All safe and secure.'" QAI required an action plan including adherence to policy regarding log entries and improved documentation of youth on enhanced supervision status: "The record should show that when a youth required crisis management services, a mental health professional was promptly notified, staff used calming strategies in an effort to stabilize the youth pending arrival of mental health staff, and that the youth was reassessed during and prior to the removal from enhanced supervision. Clinical contact notes should include information about the youth's current mood, if there was a change in status, and whether any modifications were needed in terms of safety planning."

FUTURE MONITORING

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

The MH Monitor will review documentation of suicide assessments and rate of Suicide Watch, PSW and ALS at Taberg.

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 BBHS Facility Clinical Procedures described the Integrated Assessment, 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 is in place. Memos in 2/12 and 12/12 described the procedure for referral of youth to a committee for a mental health placement (linked to the Behavioral Health Services policy, PPM 3243.33) and complies 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. The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 48c.

Taberg staff are completing the Integrated Assessment for every resident.

Completing thorough Integrated Assessments is a time-consuming expectation of clinicians. Taberg staff continue to work on including in Integrated Assessments: (a) information from a complete review of past records, including mental health, hospital, residential, school, substance abuse and other community assessments and reports; (b) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior; (c) history of substance use and how it may be related to behavior and trauma; and (d) learning disabilities and how they appear to be affecting the resident's behavior. The thoroughness of the assessments varies (depending on whether all the sections are completed and the depth of the analysis of past and new information), and continuing progress to achieve universal high quality in the Integrated Assessments is necessary for sustained compliance with Paragraph 48.

Efficacy of interventions is discussed in Mental Health Rounds and psychiatric contact notes.

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

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 48d.

One psychiatrist is at Taberg for 10 hours per week, which allows little time for participation in support team meetings or Red Flag meetings, although he discusses diagnosis with clinicians and YCs in Mental Health Rounds and individual consultations.

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.

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 48e.

OCFS has incorporated the DSM-5 in JJIS and provided information for psychiatrists and clinicians. BBHS released a BBHS Sharepoint site (web page/portal), which includes a variety of resources for psychiatrists and clinicians. An OMH webinar included a DSM-5 PowerPoint that all clinicians were asked to participate in. Psychiatrists have been asked to include DSM 5 diagnosis discussions in Rounds. Significant DSM-5 changes for an adolescent population include: the nonaxial documentation of diagnosis; to address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, Disruptive Mood Dysregulation Disorder, is included for children up to age 18 who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol; and changes in PostTraumatic Stress Disorder criteria with avoidance, persistent negative alterations in cognitions and mood (with persistent negative emotional states), and alterations in arousal and reactivity (with irritable or aggressive behavior and reckless or self-destructive behavior); posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents.

On Site Observations Regarding Paragraph 48a-e (4/15)

In April, 2015, the 12 Taberg residents prescribed psychiatric medication had the following diagnoses (most had more than one):

ADHD
Anxiety (2)
Conduct Disorder
Depression (2)
Disruptive Mood Dysregulation Disorder (2) --one of these was listed as "Mood Dysregulation Disorder" and another was listed as "Disruptive Behavior Disorder," but these are not DSM-5 diagnoses)
Insomnia (6)
Mood Disorder (5)
PTSD

The requirement of Paragraph 48 is to "develop a consistent working diagnosis(es)." OCFS provides clinical guidelines in the BBHS Facility Clinical Procedures and the Psychiatry Manual (3/14, updated 10/14). On 1/29/14 the Director of BBHS sent a memo to all OCFS psychiatrists indicating that "OCFS has committed to having a uniform working diagnosis for each youth receiving mental health services. Changes in a youth's diagnosis should result from an updated evaluation or as a result of the support/treatment team discussion...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." The OCFS Psychiatry Manual presents psychiatry standards in DJJOY facilities (for psychiatrists and psychiatric nurse practitioners), including: psychiatric evaluations, diagnosis and symptom identification, therapy in the facilities, family engagement, prescription and monitoring of psychotropic medications, and clinical connections to OCFS staff.

The Taberg psychiatrist continues to work one 10-hour day/week. During 3/1/15-3/31/15, the psychiatrist was at Taberg four days; during the month he saw 15 residents, seven of them once, five of them twice, one three times and two four times. Once weekly Mental Health Rounds are scheduled for the day he is at Taberg. During the site visit, he called into a support team that had been rescheduled to a day he is not at Taberg. If he were at the facility more hours, he would be able to spend more time with youth and participate in support team and Red Flag meetings. One psychiatrist 10 hours a week appears insufficient given the complex needs of Taberg residents.

The QAI Review (April, 2015) at Taberg required an action plan to consistently show the use of a uniform working diagnosis (in JJIS), with supporting documentation for all diagnostic changes.

The QAI Review (April, 2015) at Taberg found that the record of the one resident who was psychiatrically hospitalized had insufficient documentation to show communication between her Taberg clinician and staff treating her at the hospital, which is required. The QAI Review required an action plan to ensure documentation of these clinical discussions in a resident's records.

FUTURE MONITORING

To maintain compliance with paragraph 48 at Taberg will require consistently thorough Integrated Assessments.

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) substance abuse history and how it appears to be affecting the resident's behavior; and (c) cognitive impairments (including language and executive function difficulties) and how they appear to be affecting the resident's behavior.

The MH Monitor will continue to review consistency in diagnostic practices and efforts to routinely arrive at agreement about what is behind a resident's behavior and how staff can effectively respond.

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

The revised PPM 3243.32 entitled "Psychiatric Medicine" (9/15/14) complies with 49a: "When medicine is indicated, the diagnosis/diagnoses, the symptoms targeted by the medicine and the rationale for use of each medicine shall be clearly stated in the psychiatrist's evaluation and contact notes located in the Juvenile Justice Information System (JJIS). Copies of the psychiatrist contact notes shall be included in the Mental Health section of the youth's medical record."

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49a.

The Psychiatric Contact Note links diagnosis with the medication prescribed. The requirement of 49a is to state "the target symptoms intended to be treated by each medication." OCFS provides clinical guidelines in the BBHS Facility Clinical Procedures and the Psychiatry Manual (3/14). The Director of BBHS sent a memo to all psychiatrists on 1/29/14 reminding them of the expectation that they clearly identify in their contact notes the target symptoms and rationale for each medication being prescribed.

The MH Monitor observed the Taberg psychiatrist explaining the rationale for prescribing particular medication to treat a resident's symptoms in Mental Health Rounds. The Taberg psychiatrist does not indicate the symptom each medication is intended to

treat in the discussion section of Psychiatrist Contact form (nor does he use the checklist of symptoms).

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.

COMPLIANCE

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with 49b.

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49b.

The MH Monitor reviewed thorough Psychiatric Contact Notes by the Taberg psychiatrist in JJIS indicating diagnosis, efficacy, side effects, and the rationale for continuing, changing or discontinuing each medication in compliance with 49b.

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) required: "The use of three or more medicines simultaneously to treat one youth is discouraged and may only occur following consultation from the supervising psychiatrist. Use of two medicines from the same class is also discouraged." A JJIS note in the youth's record documents the consult.

Discussion with the supervising psychiatrist was reflected in the Psychiatrist Contact Notes for Taberg residents prescribed three psychiatric medicines.

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

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with 49c: "The psychiatrist, psychiatric nurse practitioner and mental health clinician will assess youth for beneficial effects of medicine on the target symptoms. Clinicians meet with youth weekly for scheduled visits. Prescribers meet with youth monthly, and more often when

clinically indicated. Each youth prescribed psychiatric medicines shall be assessed by the psychiatrist or psychiatric nurse practitioner every 30 days or more frequently when clinically indicated. The psychiatrist or psychiatric nurse practitioner will conduct a clinical interview including a mental status exam of the youth, review lab results, review clinical assessments for side effects, review and sign medicine refusals, and consider any additional information provided by the clinician and direct care staff who work with the youth. This evaluation shall be documented in the psychiatrist's contact notes in JJIS. The medication treatment will be continued or adjusted as indicated by the findings."

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49c.

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

On Site Observations Regarding Paragraph 49a-c (4/15)

In April, 2015, 12 of the 17 Taberg residents had psychiatric diagnoses and were prescribed psychiatric medication:

ADHD-Intuniv
Anxiety-Effexor
Conduct Disorder-Seroquel
Depression-Celexa
Depression-Lexapro
Disruptive Mood Dysregulation Disorder-Abilify (2)
Insomnia-Benadryl (3)
Insomnia-Melatonin
Insomnia-Trazodone (2)
Mood Disorder-Abilify (2)
Mood Disorder-Depakote
Mood Disorder-Geodon
Mood Disorder-Prozac
PTSD-Zoloft

In April, 2015, two Taberg residents were prescribed three psychiatric medications: a 15-year old was prescribed Lexapro, Abilify and Trazodone and another 15-year old was prescribed Depakote, Geodon and Melatonin. The MH Monitor reviewed recent Psychiatrist Contact Notes and found that their current medication regime had been discussed with the Supervising Psychiatrist.

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.

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

FUTURE MONITORING

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

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

The MH Monitor will continue to review documentation of consultation with the Supervising Psychiatrist when three or more psychiatric medications and more than one medication per class are prescribed for Taberg residents.

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

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

COMPLIANCE

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

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

COMPLIANCE

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

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) and Policy PPM 3243.15 (updated 12/24/14) entitled "Refusal of Medical or Dental Care by Youth" comply with 51a. PPM 3243.32 contains procedures when youth refuses psychiatric medicine.

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) and Policy PPM 3243.15 (updated 12/24/14) entitled "Refusal of Medical or Dental Care by Youth" comply with 51b. PPM 3243.32 contains procedures when youth refuses psychiatric medicine.

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.

In addition, the revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) requires that: "The psychiatrist or psychiatric nurse practitioner shall exchange information about the youth with the assigned clinician, counselor and other team members on an informal basis. This exchange of information will also occur at mental health rounds attended by the psychiatrist or the psychiatric nurse practitioner. The psychiatrist and psychiatric nurse practitioner attend weekly mental health rounds with other members of the support/treatment team including teachers, clinicians, YCs, YDAs, nurses, and recreation therapists."

On Site Observations Regarding Paragraph 51a-e (4/15)

The QAI Review (April, 2015) at Taberg required an action plan to address communication about and documentation of youths' refusals to take prescribed medication, particularly communication with the parent which is not always in records: "This is an important aspect of treatment and will allow for members of the youth's Support Team to explore the reasons surrounding refusal. Additionally, exploration of a youth's medication refusals corresponds to assessment of the effectiveness of the interventions specified in the ISP. Medication refusals could be related to treatment-interfering behaviors or based on adverse side effects. It is important for the Support Team, including the youth's parent/guardian/caregiver, to address these issues so that the youth's ISP can be modified, if needed."

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with the requirements of 52 and contains guidelines for informed consent for psychiatric medicines: "The assent and understanding of the youth shall be sought for psychiatric medicines. The youth needs to understand, in accordance with his or her developmental ability, how the medicine may impact the way he or she feels, acts, and thinks, as well as the benefits and risks of treatment. To obtain assent, the psychiatrist shall discuss with the youth in person, the name of the medicine, the dose, and the reasons for prescribing, common side effects, and potentially serious side effects, and obtain the youth's verbal assent to comply with the treatment. The youth's verbal assent will be documented in the psychiatrist's evaluation or contact notes."

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.

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 and how to utilize both in support teams.

"The NY Model: Treatment Team Implementation Guidelines" complies with 53a.

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.

Sustained compliance with 53c requires that the Taberg psychiatrist continues to participate in support teams of residents with complex diagnoses and/or psychiatric medicine issues.

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 has made progress in more consistently describing the specific effects of trauma on each resident's thinking and behavior in Integrated Assessments, support plans and Mental Health Rounds. 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 achievement of goals, and trauma must become a safer topic in the process of residents changing their thinking and behavior. Compliance with 53d means continued improvement in support plans to show a girl's understanding that anger, sadness and anxiety from the past dominate her reactions in the present. More improvement in staff changing their responses to residents as a result of Intact Team discussion of DBT skill-building and residents feeling safe as part of the process of trauma recovery is necessary.

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. Taberg support plans are gradually moving away from universal goals such as "Leave Taberg" or "Go home" and instead writing specific goals that fit the individual and describe changes in trauma response, relationships, and substance use that tie directly to future success in the community. Consistently strong support plans—including building from the Integrated Assessment, resident-specific change goals (composed with staff guidance) and all team members' interventions (not just clinicians)—are being monitored to determine full compliance.

"Goal Writing and Support Plans in the New York Model" provides 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 achieve their goals is stressed as an important part of writing support plans. Specific examples of the words residents use as they safely explore trauma-related goals, such as their reactions to not getting what they want and being triggered by reminders of past victimization would be useful for Taberg teams.

As support plans have evolved, it appears than an unintended split has occurred between the resident's statement of a simplistic goal and the objectives written in professional jargon which contain the changes in trauma response, relationships and substance abuse that it is essential for her to embrace. A resident is asked to state her goals, but what she must feel ownership of is what now is contained in objectives in wording she may not understand.

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 (4/15)

The MH Monitor observed two excellent Taberg support team meetings, both demonstrating strong relationships with girls and crucial involvement of CMSO and family.

Prior to her support team meeting, one resident (who just turned 16 and had been at Taberg for 14 months) had a support plan that sensitively reported: "During this review period she disclosed a history of abuse with her adoptive parent who is being investigated by CPS. This has caused major changes in her release planning and contributed to her feeling isolated from her family and unsure of her release options. She has historically been defensive regarding expression of vulnerabilities and has resorted to aggression to manage difficult emotions. Her ability to articulate abuse and fear of returning home demonstrates greatly improved trust in staff and confidence in navigating these difficult changes. Due to her history of trauma, past sexually harmful behaviors and gender identity as male (although she still wants to be referred to as she), she presents complex issues in planning for placement outside of Taberg. The support team is collaborating to identify trans-friendly foster care. She also needs continued support in managing her relationships with family (especially because her mother opposes her transition to a male)." Convened by her YC and clinician, her support team meeting also included her teacher, a nurse, the Assistant Director for Treatment and the CMSO who had driven from Buffalo. It was a complicated support team meeting consisting of several parts. In the first phase of the meeting Taberg staff summarized new developments for the CMSO and the resulting changes in release planning. The CMSO was encouraging, having identified possible LGBT services in the community. Her adoptive mother was called for the next phase of the meeting—she said it was her daughter's "fault she turned into a delinquent." They reviewed her goals with her mother and her clinician said her behavior, emotion management, and school performance had improved. In the last phase of the meeting, the

resident arrived and they began by telling her about her many strengths. She reviewed her safety plan. They discussed her improvement in her goals: Focus in school ("grades up, improvement in patience and waiting"), Relationships ("better with staff; pushed others away in the past when you thought you were going to be rejected; doing a good job trusting clinician"), and Managing emotions (much less drama with peers; no restraints or fights; used to punch people, now less reactive to emotions; talking more, acting less, opening up more). After her mother had to leave the call, the resident had an open discussion with her team about her placement preferences, and her clinician concluded "Your team supports you in finding a new family after what you've been through."

The second support team meeting was a 14-year old [redacted] resident at Taberg five months. Her history includes exposure to domestic violence, emotional abandonment by parents, physical abuse and sexual abuse. Her mother is a substance abuser who has been incarcerated. She is in DSS custody, and in the past had multiple foster home placements; she was hospitalized twice in 2013 for cutting. She used alcohol, cannabis and oxycodone. After running away from her second residential placement, she was sent to detention by DSS. She arrived at Taberg feeling hopeless, with neither parent being able to offer her a home. Her IIP was: Validation (show concern for her emotion--doesn't like her anger not to be taken seriously); Undivided attention (motivated by relationships); and Hurdle help (likes encouragement). Her support plan reported: "She is looking forward to helping on her father's farm when she returns home; she enjoys horses. She and her family have a strained relationship however recently her father has taken a more active role in her treatment and has expressed wanting her to return to his home where she is looking forward to being with her younger brother." Her support team was convened by her clinician, with two YCs, the substance abuse clinician, her teacher, the nurse and the Assistant Director for Treatment; her father's partner was on the phone; the Taberg psychiatrist was on the phone because her support team meeting was re-scheduled to a day he was not at Taberg. After the home assessment of a cousin was not approved, her father and his partner expressed a willingness to have her with them. Their home assessment was characterized as "approved but high risk" in part because her father works 12-hour days. She was disappointed when her mother relapsed because she thought her mother had been doing well (and she may have hoped for placement with her). Her father says their mother is a negative influence on the children and he does not want her to communicate with her except supervised in a government building (in the past she has run away from placement to find her mother). When she joined the team with her mentor, she showed how pleased she was when the team commended her many strengths, including telling her "You are completely different than you were when you arrived." Her goals and progress were reviewed: Goal #1 Do better in school (her grades are excellent; she has less severe moods so classes are going well; release is suggested in late June after she takes the Regents). Goal #2 Cope with trauma (her relationships are much better; she realizes she pushed staff away; in the meeting they told her, "In the future, you're going to have people who want to help you and won't leave you"). Then the team discussed her goals at home and she said, "Not to use. I ran away from problems. Drugs made me not think about anything. I'm not running away from problems here." She asked, "What does it mean, 'the services I get here, take them home'?" Her clinician responded, "We're going to problem

solve the ways you can deal with situations at home." She said, "I haven't lived at home in years so I don't know what the problems will be."

Taberg support team meetings continue to be outstanding. Staff are working to make support plans unique for each resident and to have goals incorporate trauma-related change, relationship-building and relapse prevention. Goal-writing with girls is not easy, but it is crucial to support them in specifying "What has to change for you to be successful after Taberg?" The youth's answer to that question will also be the guide for how she will be successful at Taberg (not because her goal is program compliance but because what has to change for community success also has to change for success on the unit with peers and staff). The goal in improving support plans is not to have each part of the form in JJIS completed, but to have a document that is helpful to and used by the resident, all staff, her family and community supporters.

Between 1/1/15-3/31/15, support was provided to Taberg by four BBHS staff. Ms. Lang made 41 visits to Taberg, increasing her time there at the request of the Director because of a "lack of people in the middle management role and a still fairly new clinical team." She focused on orienting a new YC, working with staff to improve the DAS and phase advancement process, and the Egregious Behavior Protocol as well as "making sure that an understanding of trauma history and substance abuse was properly documented and integrated into the plans for youth." Ms. Rivera-Barrett visited Taberg 11 times (1/7/15, 1/9/15, 1/14/15, 1/16/15, 1/21/15, 1/23/15, 2/11/15, 2/19/15, 2/27/15, 3/13/15, and 3/20/15). She provided support team observation and consultation, coached a new YC and the new substance abuse clinician, insured Innervisions and Triad groups were being convened weekly on both units, discussed the use of the Girls Circle curriculum, and observation and consultation on a DBT group. Ms. King, the Social Work supervisor, visited the facility 21 times (1/9/15, 1/16/15, 1/20/15, 1/23/15, 1/29/15, 1/30/15, 2/4/15, 2/6/15, 2/12/15, 2/13/15, 2/18/15, 2/20/15, 2/25/15, 2/27/15, 3/2/15, 3/12/15, 3/18/15, 3/19/15, 3/20/15, 3/24/15, and 3/25/15), and provided CRP Booster training to clinicians and CRP training for YCs, consultation on improving support teams, the sleep hygiene protocol, and DBT diary cards, guided a role play of a DBT skill in an intact team meeting, and coached a new YC and provided clinical coverage while clinicians attended DBT for Substance Use Disorders. Dr. Tomassone visited Taberg 11/21/14, 12/4/14, 1/22/15, 2/5/15, 4/3/15, and 4/10/15, meeting with the Assistant Director for Treatment and clinicians. One focus was suicidal behavior, helping clinicians "minimize the secondary impacts (including secondary gain to youth) of repeated and multiple watches while maintaining appropriate safety for the youth in care. They are asked to make very individualized assessments and to be specific with staff as to any special instructions regarding a watch (e.g., high engagement vs. low engagement)." Another concern was a "high number of returning youth, particularly those who had significant behavioral and emotional issues during their first time(s) in the program. Special plans have been created for individual youth, and although an often effective intervention, they are typically labor intensive. This creates a systemic tension as resources are 'borrowed' or 'reallocated' to address instant problems which often results in the creation or eruption of problems elsewhere." In addition, Dr. Tomassone convened conference calls every three weeks to coordinate the work of the New York Model coaches who were at Taberg (Bev King, Shaun Lang, and Melinda Rivera-Barrett). In addition, Brad Beach DBT consultant, was at Taberg

for a day to provide consultation on ISP goals/objectives/intervention, case formulation, and coaching staff on skillful behaviors, improving effective supervision and response to youth, which has a positive impact on youth engagement in program and reduction in program disruption.

The QAI Review (April, 2015) at Taberg observed a support team meeting in which "the collaboration, open dialogue, and teamwork were inspiring to observe. The meeting seemed grounded in the New York Model's beliefs and assumptions. A core group of staff had come together to pro-actively manage some of the youth's most challenging behaviors and they were beginning to see the success of their teamwork reflected in the youth's progress. All seemed to agree that the achievements were worth the effort and that they benefitted by supporting one another through the implementation of the youth's specialized program."

The QAI Review (April, 2015) at Taberg required an action plan almost identical to one in the 11/14 QAI Review "to improve the timeliness of ISPs being completed at every Support Team Meeting, every 30 days. The details of the ISP should reflect the team's knowledge and consideration of the youth's IA. Provide a plan to help all Support Team Meeting members offer an intervention in all ISPs, as it pertains to their roles in assisting the youth achieve her individualized and measureable goals and objectives. Also, the team members should provide a detailed summary of the progress related to their specific interventions, or lack thereof, made by the youth since the prior Support Team Meeting. Finally, the plan should include a manner to promote consistent documentation of all recent suicidal behaviors a youth was engaged in during the treatment review period as well as a response plan."

FUTURE MONITORING

The MH Monitor will continue to review support plans to verify improvement in helping residents articulate personal change goals for which all staff on their teams identify what he/she will do to support each resident's daily steps to be able to be successful after Taberg.

The MH Monitor will continue to review support plans to verify improvement in addressing the trauma behind behavior problems identified in Integrated Assessments that must be incorporated into the support plan goals and treated at Taberg.

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

The MH Monitor will continue to verify that the Taberg psychiatrist participates in support teams of residents with complex diagnoses and/or significant psychiatric medicine issues.

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.

PARTIAL COMPLIANCE

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

BBHS Facility Clinical Procedures Using the Juvenile Justice Information System (updated 11/7/14) specifies: "All youth who enter DJJOY with histories of substance abuse or dependence and are assessed as requiring continued intervention will receive treatment for such. Many facilities have substance abuse clinicians who offer pull-out individual and group treatment. For youth being treated by both a primary clinician and a substance abuse clinician, it is important to ensure that the youth's support plan reflects the work of both clinicians. Clinicians need to coordinate regularly around treatment. Regarding instances where a substance abuse clinician is not available, the primary clinician is tasked with providing substance abuse treatment, which will be reflected in the youth's support plan and contact notes. Youth requiring continued support/treatment/intervention following release from facility for addiction will require a relapse prevention plan as part of release planning."

Taberg's substance abuse clinician arrived in 2/15 and provided individual and group substance abuse treatment. But during the April, 2015 site visit she announced she was leaving Taberg. Since all the clinical positions are not full, without a substance abuse clinician Taberg is unable to comply with Paragraph 54.

On Site Observations Regarding Paragraph 54a-b (4/15)

Taberg is making progress in reflecting residents' history of substance use in Integrated Assessments and including it in goals in support plans. Applying skills being learned in the facility to successfully avoid returning to substances in the community should be an ongoing goal of services documented in contact notes and support plans. Relapse prevention plans should be included in re-entry planning. 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 will support each Taberg resident's individual progress in self-calming and relying on these skills to avoid substance use in the community.

The BBHS Substance Abuse Coordinator visited Taberg on 3/6/15 and clarified the new substance abuse clinician's responsibilities:

Identifying Need. Youth arriving at Taberg with a Special Needs and Assessment Profile (SNAP) score of 3 or 4 will be flagged by the Assistant Director for Treatment, who will add the names to a spreadsheet and notify the substance abuse clinician to conduct an SA evaluation.

Evaluation Process. Within two weeks of a youth being admitted to the facility, the substance abuse clinician will conduct a comprehensive evaluation to identify the services needed. Results of the assessment will be tracked on the spreadsheet, as well as uploaded to JJIS in the youth's individual record. Recommendations may include prevention education, pull out substance abuse group treatment, and/or individual treatment.

Prevention/Education. All youth participate in Innervisions curriculum run by YCs.

Substance Use Group Treatment. For youth who require substance use group treatment as determined by the results of the evaluation and recommendations by the substance abuse clinician, pull out groups will be provided on a weekly basis. The pull out groups will be conducted by the substance abuse clinician using the TRIAD curriculum.

Individual Substance Use Treatment. Based on the evaluation and recommendations made by the substance abuse clinician, youth will receive individual treatment addressing substance abuse at a minimum of two times per month. The substance abuse clinician will provide individual treatment for youth with substance dependence or who otherwise need intensive services. Generic clinicians will provide individual SA treatment for youth with lower or less-intense need for treatment, and the SA clinician will be available to the clinician for consultation.

Relapse Prevention. Youth who participate in pull out substance abuse treatment groups and/or individual substance abuse treatment will engage in developing relapse prevention plans with the support of the substance abuse and/or primary clinicians. A format for "My personal relapse prevention plan" was provided. Relapse prevention plan information and strategies will be incorporated into the release portfolio as well as re-entry planning.

Collaboration between Clinicians. The substance abuse clinicians will attend, when possible, the support team meetings for youth who participate in pull out treatment groups and/or individual treatment. The substance abuse clinician will provide guidance to generic clinicians and other support team members regarding the youth's treatment.

At the time of the BBHS Substance Abuse Coordinator's 3/6/15 Taberg visit, she found the substance abuse clinician's progress notes well-written and current and she had begun facilitating the TRIAD group on both units (with a total of 12 girls).

During this April, 2015 site visit, the substance abuse clinician was seeing three residents once/weekly who had SNAP scores of 4. For other residents with SNAP scores of 3, the substance abuse clinician was consulting with their individual clinicians. The substance abuse clinician actively participated in one of the support team meetings observed by the MH Monitor. The substance abuse clinician was articulate about the connection between trauma and substance abuse and the importance of treating both together. She argued for starting where a resident is—what she wants to change—and connecting it to her substance abuse, including daily marijuana use as a coping skill. In her short time at Taberg, she had been working to encourage a goal of being successful at home to which substance abuse can be tied (instead of goals of completing the Taberg program or leaving Taberg which do not connect to change necessary to avoid substances).

The substance abuse clinician also had 15 residents in Triad groups on two units; a total of seven Triad groups were convened 3/1/15-3/31/15.

The MH Monitor observed a Triad group for seven residents on one Taberg unit, convened by the substance abuse clinician. The residents were unenthusiastic about having group until the substance abuse clinician announced an activity: making a motivational poster for yourself (this connected to self-worth messages of the first section of TRIAD which they had completed—she had handouts of self-appreciation they could use for ideas). They enjoyed the markers, colored paper, and puffy letters she provided. They were still hard at work more than 30 minutes later. The Assistant Director for Treatment, the substance abuse clinician, and YDAs sat at different tables with the residents to provide encouragement and there was no friction among the girls. The substance abuse clinician pointed out multiple uses for the motivational posters, including in individual therapy and relapse prevention planning.

The QAI Review (April, 2015) at Taberg concluded that "the provision and documentation of substance abuse programming and services requires immediate improvement" and required "action plans, both short and long term, to improve the completion of comprehensive evaluations, provision of individual and group interventions, and provision of the Innervisions curriculum. The records should reflect the reasoning when evaluations and interventions are warranted but not provided and/or deferred."

FUTURE MONITORING

The MH Monitor will continue to review documentation that substance abuse assessment results are in Integrated Assessments, incorporated in the goals and interventions in their support plans, including a relapse prevention plan, and in their Community Re-Entry plans and that all youth with substance abuse diagnoses at Taberg are receiving individual (minimally twice per month) and group (minimally once per week) substance abuse treatment reflected in clinical contact notes.

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 Community Re-Entry Plan complies with 55b.

BBHS Facility Clinical Procedures using the Juvenile Justice Information System (updated 11/7/14) specifies: "The community re-entry plan, like the Integrated Support Plan, is a multi-disciplinary exercise. All members of the youth's support team are responsible for recording the course of services and outcomes for that particular discipline throughout the youths stay in facility. Each support team member will also record any ongoing identified needs, what support services are necessary for the youth's successful transition from facility and any appointments established for that youth. The clinician is further responsible for updating any final changes to the DSM diagnosis and is responsible for completing the Continuity of Care Plan (COC). The COC is the record of all established appointments with mental health and/or substance abuse providers in the community."

Taberg is completing Community Re-Entry Plans, but a primary purpose of the last support team meeting before transition and of the Community Re-Entry Plan is to tailor the youth's goals to success in the community, so her supporters understand their role in helping her regulate emotions, tolerate distress, and avoid relapsing. The Community Re-Entry Plan is 20 pages of fill-in-the-blanks disconnected units of information. It is not a document that can be easily referred to for guidance about how to support youth in the community. OCFS indicates that the CRP was designed to allow each section to be printed on its own, depending on the type of referral/provider, and a CRP workgroup has been created.

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, and 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 (4/15)

The Taberg Assistant Director for Treatment and clinicians received Community Re-Entry Plan training in December, 2014, and other staff were subsequently trained in CRPs. Taberg staff had begun to complete Community Re-entry Plans at the time of the April, 2015 site visit.

The MH Monitor reviewed a Taberg Community Re-entry Plan, and both the content and format were problematic. [redacted] is a 15-year old admitted to Taberg 7/24/14 and released 4/20/15. Her release was delayed because [redacted] was still residing in the home; she was released with assurances from her mother that he had moved out. [redacted] Integrated Assessment described a significant trauma history. It was inadequately summarized in the Community Re-Entry Plan as: "It is alleged that [redacted] is the victim of physical/sexual abuse and was raised in a domestically violent home. CPS and preventive services have historically been present in the home, resulting in a reported safety plan that alleged abuser was not allowed to be left alone with [redacted] and siblings. [redacted] increased behavioral issues (AWOL, lying, ungovernable behaviors at home and school, and school suspensions) began around the time that she reported being raped by him. [redacted] was in residential placements prior to her adjudication of assault which led to placement with

OCFS." The importance of trauma history is explaining to her community supporters how past trauma specifically affects present behavior. The Community Re-Entry Plan noted her diagnosis of PTSD, but did not reflect the work [redacted] and Taberg staff did to help her begin to recover from trauma, including understanding the connection between past victimization and her anger and developing skills to manage her emotions when in distress and avoid triggers for substance abuse. Her goals from the facility are listed as her goals in the Community Re-entry Plan, and they have not been re-written with her to anticipate the challenges to achieving them without Taberg support. Goal #1 Become a counselor: "Discuss healthy coping strategies to manage the urges associated with her top triggers for substance abuse." The specifics of what she can to do when she is tempted to calm herself with substances, and the other ways in which her career goal can motivate daily choices should be included as guidelines for [redacted] her family and community supporters. Goal #2 Complete high school: "Doing her work in all classes." What it will take to stay focused on her school goal, with all the distractions in the community, and who can help her, should be specifically explored with her and recorded here. Goal #3 Leave Taberg and return home to Mom: "In order to create a safe environment youth will develop effective responses to trauma-related cues." To be useful at home, this objective should state—without jargon—what [redacted] her mother and others can do to make her feel safe, especially because of her fears and anger about her mother's continued involvement with [redacted]. Furthermore, nothing is clarified following her goals and progress in a section called Needs/Goals which is organized by staff person and consists of directives to participate in community services, not a strengths- or needs-driven, relationship-based, trauma-responsive approach. The course of treatment section of her Community Re-entry Plan is not written in a way that would help [redacted] her mother or community staff use the skills she learned at Taberg to cope successfully with trauma triggers at home and community school ("She has been offered psychiatric services, individual trauma informed therapy, daily group therapy, Triad substance abuse group treatment"). The Mental Status Exam in [redacted] Community Re-entry Plan is undated; mental status is a current assessment, and if it is from the past, it has little relevance. Finally, the Community Re-Entry Plan stated, "[redacted] is highly motivated by individual attention from trusted staff. During moments of crisis, [redacted] has been engaging with trusted staff." Like other traumatized adolescents, it will take a long time for her to develop trust in community staff and her mother, and because trusted adults are essential to her successfully continuing to use her new skills learned at Taberg, she is at high risk of emotional dysregulation leading to re-entry failure. B2H may participate in the last support team meeting at Taberg to make contact with residents, but [redacted] Community Re-Entry Plan does not reflect the special, intensive effort it will take to bridge her reliance on trusted Taberg staff.

The two hour Community Re-entry Plan training and initiating Community Re-entry Plans are an improvement in compliance with subparagraph 55b at Taberg since the November, 2014 site visit. The Community Re-entry Plan form does not capture Taberg's extensive work to prepare community placements for residents nor does it provide the youth, her family or future providers with details about how her progress in recovering from trauma, managing her emotions, developing trusting relationships and avoiding triggers for substance abuse will continue in the community. The Community Re-entry Plan must be a document that can be easily referred to for guidance about how to support a

girl in the community. Goals from her facility stay must be translated into goals that are meaningful in the community, and the Community Re-entry Plan must be written in a way that would help her, her parent and her CMSO use the skills she learned at Taberg to cope successfully with challenges at home and community school, linking trauma history to behaviors and emotional regulation in a way that is understandable to family and service providers. The lack of a usable guide for re-entry success contributes to girls not continuing their Taberg gains in the community.

Furthermore, while the recent expansion of treatment foster care is a welcome long-needed systemic improvement, a continuing re-entry barrier for Taberg residents is that step-down placements do not provide sufficiently intensive services to prevent girls' adjustment behaviors leading to discharge. For example, [redacted] (described earlier in this report) has finally, after years of suicide attempts and out-of-control anger, become involved in trauma treatment at Taberg. For her to make a successful therapeutic transition from her Taberg clinician to a community trauma treatment provider will be complicated, beginning with relationship-building with a therapist in the community before leaving Taberg as well as making other community supporters aware of what it will take to assist her in using distress tolerance skills and avoiding being triggered to use substances. With her trauma history, [redacted] is at high risk for relapse and getting angry at community staff and educators. At almost 18, she is unlikely to be a Taberg returnee, but lack of success in a community placement could result in future hospitalizations, adult incarceration and not being able to make use of her intelligence and talents.

FUTURE MONITORING

The MH Monitor will continue to review Taberg Community Re-Entry Plans to verify improvement in their usefulness for youth, families, and providers to support the continuation of the resident's progress in the community.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. Document Development and Revision. Consistent with paragraph 68[2] of this Agreement, the State shall create or modify policies, procedures, protocols, training curricula, and practices to require that they are consistent with, incorporate, address, and implement all provisions of this agreement. In accordance with paragraph 68 of this Agreement, the state shall create or modify, as necessary, other written documents – such as screening tools, handbooks, manuals, and forms – to effectuate the provisions of this Agreement. The State shall submit all such documents to the United States for review and approval, which shall not be unreasonably withheld.

COMPLIANCE

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

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:

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* (April 9, 2015) (also referred to as the QAI Review of Taberg) and had an opportunity to discuss its contents and findings before the Taberg monitoring visits. Again, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors. The quality of QAI products has become an important source of information in the monitoring process. The quality of the QAI Reports has been excellent. The reports have been thorough and informative.

QAI implemented the Graduated Response System (GRS) as a powerful quality assurance tool, incorporating performance metrics developed with the assistance of OCFS' Bureau of Strategic Planning and Policy Development. QAI reviewed with the Monitors the development of these restraint metrics and how they will be linked to GRS protocols and action plans. More importantly, this QAI initiative recognized that reliable critical performance metric/restraints safeguards influence the monitoring in ways that expedite agreement among the Parties about compliance. Home Office, QAI, and the Finger Lakes TIC validated GRS at Finger Lakes, so the Monitors again verify the effectiveness of the system. The Home Office and facility TICs have become essential elements in the use of the GRS, serving as primary agents for problem-solving and stability regarding Protection from Harm and Mental Health programs in the living units.

Reducing the time between the discovery of a problem and its resolution also increases the likelihood of successful outcomes, and this could occur through the implementation of the previously mentioned track system at Taberg. Such a track system would increase the sensitivity to individual youth variables (e.g., a new youth has arrived, a youth gets bad news, a conflict from the street emerges) and permit the development of immediate strategies such as one-on-one, intensified mentoring, etc. to fit the youth. This aspect of GRS needs strengthening, and the Monitors recommend a quick movement to a track system at Taberg that uses current restraint data.

Many variables exist in operating a multi-unit facility that may sometimes create temporary circumstances where uses of force move into a GRS "red" level. Because GRS yellow levels are associated with special activity and involvement by the facility and Home Office TICs, the continued GRS "red" level signals the need for additional problem solving actions through the leadership of Home Office. While a GRS "red" level reflects urgency for additional immediate Home Office and facility interventions, moving a GRS "red" level to yellow or green within 60 days would support a compliance finding. The GRS "red" level 60-day parameter means no more than two consecutive GRS "red" levels before moving to

yellow or green. In the event of a "red" GRS level for more than 60 days, Home Office would be expected to explain the circumstances contributing to the "red" level for the Monitors' consideration in making compliance determinations. Since the GRS system has already demonstrated this capacity, the challenge at Taberg is not with GRS but finding and implementing a strategy to address uses of force that move the GRS level out of the "red" (see discussions at Paragraphs 42b and d).

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: Crisis disruptions of normal operations that result in reductions in youth safety and increases in uses of force should initiate discussions about special, additional QAI critical reviews and evaluations of the OCFS crisis management plans.

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: The Monitors substituted the final OCFS Response Plan as the corrective action plan permitted under this paragraph, and a tentative agreement exists with the justice center that would substantially reduce the amount of time between the start of a staff sexual abuse allegation and if findings letter and report. In addition Home Office has reported monthly and updated sexual abuse allegations using the Monitors' Taberg Sexual Abuse Findings Table supplied to OCFS as an Excel spreadsheet. The Monitors request the continuance of this practice until the next monitoring visit.

V. SUMMARY

Taberg staff should be commended for uniting in adversity and continuing their commitment to returning to a therapeutic, safe, and stable environment. Since the spring of 2014, during a stressful, extended crisis that affected them all, Taberg staff have maintained a professional demeanor and displayed a remarkable resilience.

The impending transition in key leadership and clinical positions about which the Monitors' expressed concerns at the April 2015 site visit occurred shortly afterwards. The Monitors remain concerned about the safety and progress of Taberg residents given staff vacancies, prolonged searches for replacements, the presence of substitute and temporary clinicians and other staff, the overall loss of stability and the possibility of problems similar to those experienced in the spring and summer of 2014. Home Office provided an update on the status of Taberg at the Finger Lakes monitoring visit in May, 2015 which included Home Office strategies for providing and augmenting various essential services. The Monitors requested monthly email updates to include population, status of filling positions, restraints, SWs, PSWs and ALS, new admissions, and returnees at Taberg. Until the Taberg clinical positions are filled, the Monitors recommended that Home Office keep the Taberg population at 18 or below. This is a safety recommendation based on the summer of 2014 experience of having Taberg at capacity with high-needs girls. While the Monitors understand that Taberg is the only limited secure and MHU for girls in the state, the Monitors encourage Home Office to continue and expand its efforts to assist private providers to function more effectively by requiring individualized intensive mental health

services to prevent new admissions and returnees from going to Taberg because their needs were not met in these programs.

Taberg is nearly full, and all the girls are extremely needy trauma victims who continually try to engage staff in control battles. Most of the girls on both units have challenging behavior driven by trauma and many do not have a re-entry placement likely to provide permanency and adequate support to continue the progress they make at Taberg. There are three clinician vacancies at Taberg, as well as YC and other vacancies. Two clinicians, one also acting as Assistant Director for Treatment, cannot cover large caseloads of such needy girls. There are simply too few Taberg staff for more than 18 challenging residents. Many staff work long hours that make them less effective. The frequency of use of force and suicide watches are indicators of insufficient stability on the units.

Recently Home Office reported the Taberg population is at its rated capacity of 23 girls; yet, it has many of the characteristics of a crowded facility. Twenty-three is 192% of the population at Columbia in August 2013 when the Monitors recommended sustained compliance with Protection from Harm and Mental Health. There are many reasons why comparisons between Taberg and Columbia are unfair, but the physical space used for daily living is the same, so social density comparisons apply. Crowding is a powerfully negative factor in conditions of confinement and the many variables contribute to fear of safety for youth and staff. Crowded facilities rarely have effective programs or sufficiently safe conditions.

Home Office has taken substantial steps to reduce the negative impact of the staffing and population problems. The analysis of use of force data has become more in-depth and evidence is emerging that the Taberg use of force rates may be more related to individual youth than population variables. This perspective has support through the recent data analyses conducted by the PH Monitor that show for the first time no significant correlation between changes in population (as measured by the monthly total days care) and the monthly rate of physical restraints. These findings suggest that something different is happening at Taberg that does not follow traditional population/use of force relationships. If this is the case and the primary factor in use of force rate fluctuations is individual youth, then Taberg faces the likelihood that old assumptions about staffing and programming may no longer be applicable. The Home Office perspective suggests that certain youth require more specialized interventions in order to prevent emotional dysregulation and escalation to the point of use of force. Unfortunately, implementation of special programs has and will continue to require modifications to the staffing arrangements on each shift. These modifications do not mean fewer staff; recent experience indicates that special programs require additional staff. This returns the focus to an earlier discussion of the gap between the number of individuals on the approved or budgeted facility roster and the number of individuals within those position categories who are available and qualified to work a shift.

Taberg underscores the importance of fully integrating the Mental Health and Protection from Harm aspects of the Settlement Agreement. Improving support plans, strengthening individual trauma treatment, incorporating DBT and Sanctuary in unit life, effective substance abuse treatment and relapse prevention plans, and strong Community Re-Entry Plans are important. Taberg staff are working to enhance their skills at responding to the troubling behaviors of traumatized girls. It is essential to have a full

clinical, YC and leadership team so residents get the mental health treatment to meet their needs and that clinicians and YCs are able to support, coach, and debrief with YDAs and others who do most of the intervening with residents. Better de-escalation strategies, richer staffing to permit enhanced coaching, and strong intact teams continue to be necessary for full implementation of the New York Model at Taberg.