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 seventh 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 August 20-23, 2012. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

The Settlement Agreement (Paragraph 61b) provides for *ex parte* communications as an ongoing way for the Monitors to gather information. The Settlement Agreement further stipulates (Paragraph 62d) that the Monitors will provide a draft report to the Parties following the monitoring visit. The Monitors construe the designation of a draft report in advance of a final report to mean that the draft report and the comments provided by each Party are still part of the investigative processes associated with the monitoring visit. Therefore, the Monitors note that statements in a draft report are not final, and they are not wedded to draft report statements. The Monitors acknowledge the option to modify and clarify initial impressions and statements regarding compliance in advance of a final report. Furthermore, the Monitors' final reports apply solely to matters contained in the Settlement Agreement.

A. Tryon Girls

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

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

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

B. Facility Background Information

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

Taberg was a male juvenile facility, and it opened for girls on August 31, 2011 when 12 girls moved from Tryon. Staff came from Tryon, Taberg Boys, Annsville, Tubman and elsewhere. In the six months since the last monitoring visit, 20 staff have left and there are more than 30 new staff: one-third of the 86 staff are new since 2/12. A challenge at Taberg continues to be creating a cohesive staff team.

On August 20, 2012, there were 18 girls at Taberg, nine on the mental health Unit and nine on the generic unit. None of the original Tryon girls remain at Taberg; several were fennered to Columbia and are still there. Only two girls at Taberg were there during the monitoring visit six months ago. Half of the girls at Taberg arrived in the two months prior to this site visit.

The 18 girls ranged in age from 13 to 17. There were two 13-year olds and three 14 year olds whose immaturity was a noteworthy challenge, especially in a facility where more than half the girls were 16 and 17. The 18 girls had been at Taberg from 15 days to 328 days; four had been there longer than four months (although another one came from Lansing and has been in OCFS facilities since 12/11 and another one came from Brentwood where she was placed in 2/12). The 18 Taberg girls have been sentenced for: Criminal Mischief (5), Possession of Stolen Property (3), Assault (2), Possession of a Weapon (2), Petit Larceny (2), Resisting Arrest (1), Trespassing (1), False Impersonation (1), and Violation of Probation (1). All but two of the girls have psychiatric diagnoses: Mood Disorder, Conduct Disorder, Depression, Anxiety, Bipolar and Impulsivity. Sixteen of the girls were prescribed psychiatric medication, and 8 take more than one psychiatric medication: Seroquel (7), Abilify (4), Zoloft (3), Trazodone (2), Prozac (2), Depakote (2), Remeron (2), Lithium (1), Lexapro (1), Clonidine (1), Clozapine (1), and Cogentin (1).

C. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The Monitors submitted a list of documents for pre-visit and on-site review. The Monitors worked with OCFS to make the document production and review processes more efficient, especially ways to make the transportation of documents easier for Home Office without compromising the quality of information provided.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that were provided to the Home Office for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS) data. The Monitors received the OCFS third Six-Month Progress Report on the MAP on June 20, 2012.

Assistant Facility Director Tulino tracked restraint data on a daily basis. Her charts revealed an interesting pattern that may reflect a natural phenomenon associated with congregate living arrangements for teenage girls. Further analysis of these data and the probable causes warrant additional investigation.

The Quality Assurance and Improvement (QAI) Bureau raised accurate questions about some data integrity issues for Taberg, and the recommended corrective action plan reflects an appropriate strategy to address and resolve these data concerns.

3. Entrance Interview

The entrance interview occurred on August 20, 2012 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: Augustine Amissah, QA Specialist; Dr. Gale Asch, Assistant Facility Director – Treatment; David Bach, QAI Director; Lori Clark, Acting Facility Director; Diane Deacon, Legal; Edgardo Lopez, Settlement Agreement Coordinator; Chuck Olson, Summer Education Coordinator; Denise Passarello, QA Specialist; Beverly Sowersby, Facilities Manager; Joe Tomassone, Chief of Treatment Services; Suzanne Tulino, Assistant Facility Director; and Jenne Utting, QA Specialist.

4. Facility Tour

Walkthroughs of the facility followed the entrance interview. The Protection from Harm facility tour used copies of fire evacuation floor plans on an 8 ½" x 11" format. Youth safety issues stemming from the prior walkthrough of the facility in February 2012 are discussed below under Paragraph 44 iii 2.

5. On-Site Review

The site visit included a review of numerous documents available at the facility and not included in the pre-visit document request list. These documents included many reports that occurred in the time between the documents prepared for the Monitors and the on-site assessment. The MH Monitor observed four support team meetings (formerly treatment teams), Mental Health Rounds, a Sanctuary group and a Red Flag meeting, met with the clinicians, and reviewed eight girls' records.

6. Staff Interviews

The Monitors interviewed 18 Taberg staff. In addition to group meetings with staff, the MH Monitor interviewed a YC, a Youth Division Aide (YDA), two clinicians, and two nurses individually. The PH Monitor interviewed six YDAs, one Acting Facility Director, one Assistant Facility Director, one Regional Nurse Administrator, one Nurse Practitioner, one nurse, and one AOD, and one Youth Counselor 2. Of the six YDA staff members who participated in interviews, the average age was 34 years old with 7 years of experience, and 83% were male.

7. Resident Interviews

The MH Monitor interviewed five (5) girls individually. PH Monitor interviewed seven (7) girls with an average age of 15.0 years old and an average length of stay of 4.4 months. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on August 23, 2012. The Monitors expressed their appreciation for the cooperation and hospitality of the Taberg and OCFS staff. The Team then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance included: Edith Abete, YDA2; Augustine Amissah, QA Specialist; Dr. Gale Asch, Assistant Facility Director – Treatment; David Bach, QAI Director; Dan Bareiss, Cook; Susan Cheek, RED; Lori Clark, Acting Facility Director; Andre Cuela, Social Worker; Janice Curren, PAC; Diane Deacon, Legal; Dave DeLaOsaCruz, YC1; Dr. Rebecca Fisher, Psychologist; William Gillman, Social Worker – OMH; Audrey Kurtz, RN; Edgardo Lopez, Settlement Agreement Coordinator; Ruth Mosher, RN; Julie Noti, Social Worker; Denise Passarello, QA Specialist; Paul Piersma, AOD; Patricia Randall, Secretary; Rebecca Roberts, YC1; Beverly Sowersby, Facilities Manager; Suzanne Tulino, Assistant Facility Director; Bruce Warcup, YDA; and Jane Wenham, RN. Those participating on the phone included: Augustine Amissah, QA Specialist; Jim Barron, Director, Labor Relations; Merle Brandwene, Director, Management and Program Support; John Canino, Legal; Matt Carpenter, Executive Assistant to the Deputy Commissioner, DJJOY; Sandra Carrk, Project Manager; Dr. Michael Cohen, Medical Director; Felipe Franco, Deputy Commissioner, DJJOY; Larry Gravett, Director, SIU; Pam Kelly, Director, Bureau of Training; Ines Nieves, Associate Commissioner, DJJOY; Lee Prochera, Deputy Counsel; Lou Renzi, Legal; Dr. Joe Tomassone, Chief of Treatment Services; and Jenne Utting, QA Specialist.

D. Preface to Protection from Harm and Mental Health Findings

Taberg has made substantial progress since the last site visit. The staff has enlarged and appears to have stabilized. The New York Model is being implemented. Taberg has an extremely challenging population of girls: several staff noted that the whole facility operates like a mental health unit because the girls on both units are indistinguishable in their histories of trauma and multiple placements. Furthermore, Taberg struggles with a population with a diversity of maturity, coping with the special needs of young residents as well as those of older delinquents. Taberg staff endeavor to tailor the New York Model to address the unique needs of girls by building strong relationships with girls who are untrusting because of past trauma. Even with these challenges, Taberg had significant successes, and girls have left the facility after making considerable progress. Taberg has also struggled with scheduling problems: to achieve full YDA involvement in Mental Health Rounds and support teams, the schedule of those meetings has to change and there has to be sufficient coverage. In the previous site visit, crocheting was the girls' primary recreation, and considerable effort has gone into enhancing activities, including more off-grounds trips. Bikes have been purchased. The girls have a garden. Taberg had a 4th of July Carnival with water balloons, sprinklers, and a slip and slide. One outcome of a Home Office committee on OCFS girls was the allocation of funds to pay presenters. A reptile expert has come in with animals; Taberg plans to arrange more speakers, especially women in different careers. They also hope to arrange music, fitness, culinary and art activities using volunteers, including doing pottery with the kiln at Annsville.

Staff at all levels talked about the many accomplishments that have occurred since the February 2012 monitoring visit. However, everyone qualified their descriptions of these accomplishments by saying that Taberg is not where they want it to be. Despite these insider concerns, things looked and felt different at Taberg for many reasons, including but not limited to greater staffing stability and more programs. Other factors contributing to Taberg's improvements included an assembly of good and talented staff and the stability and continuity in leadership. Top level and middle management staff are very capable, and this factor has contributed to improved staff morale, improved staff effectiveness, and improved staff attendance. Staff at all levels attributed these improvements, in large part, to the leadership of Acting Facility Director Lori Clark and Assistant Facility Director Sue Tulino. Interviews with youth and staff identified Ms. Tulino as a common element in their various descriptions of the positive changes that have occurred.

The change in staff morale also seemed to parallel what the Monitors describe as a positive change in staff attitudes about youth. Responses from youth and staff interviews consistently described better relationships between youth and staff. Of the Taberg staff interviewed, no one indicated that they had feared for their safety at Taberg within the last 6 months. Of the youth who participated in interviews, 85.7% believed that staff are good role models and that they make more positive comments to youth than negative comments. When asked about what was different over the past six months or since the last monitoring visit, one youth approaching release who had been in the facility from its beginning in August identified five changes that have been beneficial:

1. There are more activities due in large part to the leadership of Ms. Tulino.

2. There are more programs for girls and with a greater variety.

3. The Unit now acts as a "community." It was noisy, negative, and disrespectful, but now it is quiet, structured, and cooperative. Again, Ms. Tulino was credited with adding structure and order to the Unit. Things were so negative and boring during previous times that restraints were seen as a form of activity. There was no incentive for behaving well, but that has changed.

4. There is greater confidence in staff and a trust that they are trying to be helpful. In addition to preempting a lot of disturbances and using de-escalation, a key comment was, "Staff are coming to work now." This corresponds with staff reports of increased staff morale and a greater desire to be at work.

5. Perhaps the most telling statement was her comment that "We can get along; it is safer here now."

A common explanation of the recent challenges at Taberg was that the unique characteristics of the Taberg girls brought something new every day, which is a recurrent rationale by juvenile correctional facility staff. Staff noted the complexity of peer relationships and how these dynamics contributed to emotional upset, even restraints. Descriptions of the relationship problems often included racial factors and sexual orientation and gender identity.

Staff also attributed recent improvements and stability to increased numbers of staff and increased staff training. For example, staffing adequacy (the percentage of budgeted YDA staff who are available to work on their scheduled shift) had increased by twofold since the February monitoring visit. The August staffing adequacy for Taberg was very good. Next, the New York Model was described as gaining momentum and effectiveness, and the increased numbers of staff allowed CPM to be more manageable and effective. Staff also recommended greater accountability for youth through more responsibilities for those who do well, especially increased incentives. The only complaint about the New York Model was that DAS needs more and better evening incentives.

Before this site visit, the DDJOY Quality Assurance and Improvement (QAI) Bureau completed a thoughtful review at Taberg, which was more detailed that their pilot review two months before at Columbia. The QAI review commended Taberg for a reduction in restrains, quality restrain packets, and exemplary staff.

II. PROTECTION FROM HARM MONITORING

The data on safety indicators related to the Protection from Harm Paragraphs showed improvements, including youth and staff perceptions of safety. The youth survey results affirmed the initial statements of staff that substantial progress has been made but that staff are not yet satisfied with all of the outcomes. Of the youth who participated in interviews, only 14.3% indicated that they had feared for their safety in the last six months, and they had an average safety rating of 7.6 in response to the question, "On a scale of 1-10 with 10 being the highest, how safe are you in this facility?" Some differences were noted

based on how close the youth was to release, with youth closer to release expressing more positive perspectives of Taberg and safety. The low rate of fear for safety seemed counter-balanced by the threats of fights (within the last 6 months, 28.6% had been beaten up or threatened with being beaten up) and thefts (42.9% had personal property stolen directly by force or by threat within the last 6 months), not to mention the high percentage of youth who had been involved in fights (71.4%).

Of the youth who participated in interviews, three (3) girls expressed concerns about gender-related staffing issues regarding treatment and safety. The comments related to a male counselor and what one girl described specifically as her difficulty talking to a man about "certain things." The other issue was the concern expressed by girls regarding the absence of a female staff member working the night shift. The girls commented that the presence of an all-male night shift staff made them feel uncomfortable especially during room checks. The New York Model has as a goal to improve individual safety for youth, which means that these fears should be a topic for discussion. The Monitors noted the addition of female YDA staff, who were also assigned to the night shift, which could reduce youth and staff concerns.

A. Use of Restraints

A guiding principle for monitoring is Paragraph 40, which states, "The State shall, at all times, provide youth in the facilities was reasonably safe living conditions." Many of the explanations regarding the Protection from Harm Paragraphs have assumed that there is a common understanding about the definition of "safe." For clarity, safe living conditions are places where youth are free from the occurrence of or risk of harm, injury, danger, and fear of harm, injury, and danger. Therefore, one element of a compliance decision is determining if a particular Paragraph contributes to reasonably safe living conditions.

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.

PARTIAL COMPLIANCE

COMMENT: Multiple aspects of restraints are included here. They are undue (unwarranted, excessive, inappropriate or too many) restraints, policy and procedure outlining the circumstances when restraints are appropriate, and a prohibition against the use of restraints as punishment, to name a few. The CPM policy and procedure are in compliance, so the partial compliance finding results from concerns about other aspects in the Paragraph. Additionally, direct observation of a successful de-escalation of two verbally assaultive girls that avoided physical restraints provided an alternative example of when a restraint is necessary. At Taberg, some compliance concerns existed regarding undue restraints.

Policies and Procedures

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 new policy and the physical restraint approach. Staff again provided accurate answers to the questions about these policies and procedures. The responses were consistent with the intent of the Settlement Agreement.

Undue Restraints

There still are too many physical restraints. Factoring into this determination are the regular analyses of the Home Office-supplied restraint data for Taberg, reviews of restraint packets, reviews of restraint videos, along with an understanding of restraint practices and the challenges presented by Taberg youth. Supplementing this perspective are comments from knowledgeable Taberg staff who understand CPM and who (a) describe the current rates of restraint as too high, (b) describe some restraints as unnecessary due to the need for improved staff skills, e. g., skills to avoid physical restraint associated with the full integration of the New York Model, and (c) set a reasonable and acceptable level of restraints below current practices even when taking into account the unpredictable nature of both the operational circumstances and the Taberg youth. Finally, concerns existed in more than one confidential interview with Taberg youth regarding use of force.

Regarding the data as one indicator of compliance, restraints are currently categorized into two (2) types, those that do not take the youth to the floor (standing restraints), and those that take the youth to the floor (seated and supine restraints) with the range of standing restraint options representing lesser amounts of physical control and, usually, time. OCFS keeps good enough records that permit the restraint data to be disaggregated into these two (2) sets. During July, there was a reduction in the rate of restraints, and the July data revealed a shift in the proportion of standing restraints versus seated/supine restraints with standing restraints reflecting the majority of the restraint activities. This positive indicator along with the reduction in the rates of restraints disappeared in August. The Home Office-supplied numbers for each category of restraint from February through August 2012 affirmed Taberg staff assessments that while there have been improvements, the present frequency of restraints was not acceptable to them.

Of the youth who participated in interviews, all had been involved in a physical restraint within the past 6 months. Two responses were noteworthy: 85.7% believed that staff use force only when they really need to, but 57.1% believed that staff tried to hurt them during the restraint. The numbers implied that a majority of staff follows the policies and procedures as intended, but the youth alleged that there are several staff who try to hurt them during restraints. These perceptions require closer monitoring and attention and underscore the importance of Paragraph 44e.

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

Regarding Restraint Packet #347682 (Youth LN, July 16, 2012), this was a protracted restraint. From beginning to end, the restraint event lasted 61 minutes and included five (5) separate takedowns to a supine position. Present were YDAs, an AOD, and a mental health representative, but no one raised the length of the restraint as a concern in the Restraint Packet documentation. (The MH Monitor notes on page 26 a 44-minute restraint of the same youth about a month earlier, but that Restraint Packet was not part of this review.) Similarly, the restraint in Restraint Packet #318380 lasted 28 minutes in the EBP room. There was no Video Review Form (VRF) in the packet.

The lengths of time of both restraints raised concerns. They were substantially longer than other restraints. Protracted restraints indicate that, for whatever reasons, problems exist; and for the reasonable safety of youth, they should alert staff to the need for some type of special review to safeguard that the stabilization of the situation occurs in the minimum amount of time. While the Settlement Agreement only mentions an in-restraint assessment for a face-down restraint (Paragraph 41c) and a Post-Restraint Examination by medical following a restraint (Paragraph 44c), a prior protracted restraint during a monitoring visit at another DOJ facility showed that the nature and extent of the restraint can have emergency health implications for the youth. Even though the DOJ-approved policy does not have a time limit on restraints, Home Office has proactively begun a consideration of length of restraint. Furthermore, the DOJ-approved policy does not require medical staff to monitor during restraint. Hopefully, the Home Office considerations about length of restraint will include an examination of when medical

should initiate an assessment of a youth in the restraint process based on the length of time since the beginning of the restraint.

Other considerations surrounding the length of time in restraints should include supervisory implications and Documented Instruction/coaching issues through the Facility Administrator's review. Regarding supervisory implications as contained in Paragraph 44g, in the example cited above from another facility, the non-health care individual responsible for supervising the YDAs and the youth during the restraint was assessing the health status of the youth but did not recognize the distress. There was nothing documented in these two Taberg restraints that indicated that the Restraint Monitor was trained to assess the health status of youth. Regarding Restraint Packet #341283, two nurses were visible in the dayroom during these restraints. This suggests that medical staff have access to youth during restraint situations, so the presence and involvement of medical does not appear limited to facedown restraints or the Post-Restraint Exam at Taberg. Additionally, the lengths of time in restraints were not identified as concerns in the Facility Administrator's reviews described in Paragraph 42e.

41. b. Create or modify and implement policies, procedures, and practices regarding the application of restraints to youth at heightened risk of physical and psychological harm from restraints, including, but not limited to, youth who are obese, have serious respiratory or cardiac problems, have histories of sexual or physical abuse, or are pregnant.

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. Interviews with direct care and health care staff revealed a working knowledge of conditions, circumstances, and plans that limit the restraints to youth due to heightened risk of physical or psychological harm. A review of Restraint Packets revealed no use of restricted restraint techniques.

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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. However, concerns remain about facedown restraints in light of reports from youth that they have been taken to the floor in a facedown or prone position in ways that do not conform to the requirements of this paragraph. Restraint Packet #341283 contained video of multiple restraints of five girls, two of which involved facedown or prone restraints that lasted more than three minutes. The *Pilot Program Review: Taberg Residential Center for Girls* or the QAI Report for Taberg discussed the continued use of facedown or prone restraints, detailing the number of restraints that occurred and the particular problems with each.

Policy 3247.12 describes a "transitional hold" that moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs. In response to the question about when a face-down (prone) restraint is permissible, similar to their February 2012 answers, most Taberg staff responded that a prone restraint is not allowed and that the "transition hold" is not really a prone technique because they only move a youth to her side if the application of handcuffs is necessary.

Representatives of the Bureau of Training, Debra Peete, Norm Tillery and Onna Cooley, demonstrated and reviewed for the PH Monitor the new, proposed handcuffing strategy, which would eliminate the need to use the "transitional hold" that exposes a youth to a facedown or prone position during the administration of the handcuffs. The procedure is a slight modification of the two-person seated restraint as the point of departure for the new procedure. From the seated position, two staff members move the youth's arms backward so that an additional staff member can apply handcuffs with the youth's hands behind his/her back. The demonstration appeared to be an improvement over the transitional hold, but the PH Monitor noted that the change needs to be approved by someone with medical credentials who can speak to the risk of the technique regarding possible injuries to the youth's shoulders and elbows.

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

COMPLIANCE

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

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: Printouts from the STARS system for (a) CPM, (b) first aid, CPR, and AED, (c) CPM Refresher #1, (d) CPM Refresher #2, and (e) the New York Model were provided by Ron Rutledge and reviewed line-by-line with him. Regarding the status of employees with up-to-date CPM training, only two staff members did not have up-to-date training. One was a new hire who was scheduled to be in the next training, and the other was a staff member who had just returned from Worker's Comp.

B. Use of Force

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

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: Data regarding the use of force are mixed. Of the Taberg staff interviewed, 67% reported that they have been investigated for abuse or use of excessive force or inappropriate use of force, but none have had a substantiated finding as the result of an investigation. Of the youth interviewed, all had been involved in a physical restraint and 57% believed that staff had tried to hurt them during the restraint. Another 43% claimed they were injured as a result of a restraint.

A YDA2, see paragraph 44 e, was found guilty of misconduct that included excessive force by pressing his full body weight on a girl during the restraint, by spitting on her, and by kicking her in an April 2012 incident. Resolution of the case is pending.

The Use of Force section of the Taberg QAI Report identified inappropriate or excessive uses of force in Restraint Packets 300680, 300183, and 302580. Also Restraint Packet 334284 provided evidence that a staff used his elbow to hold the youth's head down during restraint.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. However, documentation problems existed, which need correction.

For example, in Restraint Packet #318380 at the end of the video supplied by Home Office, the youth was in the EBP room with a male staff member, but there was no documentation about what was going on or who the male staff member was. This one-on-one session lasted approximately 45 minutes, so the assumption is that there should have been documentation.

Concerns still remain about the quality of the documentation of a Post-Restraint Examination (PRE) that does not occur in the clinic. See Paragraph 44 c for additional explanation of this issue.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff members report a practice that is consistent with the policy and procedures. 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.

Missing from the implementation of the policy and procedure are protocols or guidance regarding the ways in which information gathered in this process should be used to improve training and supervision and to revise policy or programs. Additionally, protocols for the senior management review of information are "in progress."

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist, and there is a practice in place. Throughout the monitoring process, this paragraph has become more important because of the "review" and "evaluate" functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to continue the evolution and improvement of CPM and the New York model. With the advent of QAI, it

provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Similarly, reviews of the physical restraints provide an additional opportunity to raise issues related to the prevention of unnecessary restraints. While an unnecessary restraint may more appropriately fall under Paragraph 42b regarding the least amount of control needed to resolve the situation, the current paragraph has evolved to the point where some of these auxiliary issues are more relevant here. Therefore, much of the narrative for this paragraph identifies issues that affect the nature and extent of physical restraints.

The picture resolution on the videos is significantly improved.

1. Documented Instruction (DI)

Regarding Documented Instruction, the QAI Report noted that in several instances there was evidence of Facility Administration requesting Documented Instruction; but there was no evidence Document Instruction took place.

There were several issues that arose from the review of the Restraint Packets that related to Documented Instruction.

Restraint Packet #341280. A Documented Instruction was requested for all staff members involved in this incident because they did not move other residents into their rooms. Thus, there were too many youth in the area, which may have added to the problems in containing the situation. The documentation does not indicate the outcomes.

From the video review in the Restraint Packet, it appeared that the inability to successfully implement a single person standing restraint resulted in the youth breaking free, which escalated the restraint and ended in a two-person seated restraint with one staff member holding the youth's arms and another staff member holding the youth's legs. There was no mention of this on the Video Review Form and no referral for Documented Instruction.

From the video reviewer's perspective, it is the youth's behavior that has to constitute an imminent threat of harm due to the absence of audio. Because there was no reference in the written materials to loud or threatening behavior on the part of the youth, the restraint was initiated as a result of tipping over chairs in a direction away from staff. In general, verbal threats and other verbal behaviors by themselves would not reasonably qualify as imminent danger. With two YDA staff members in the area along with a teacher, more time and effort could have gone into de-escalation and the youth's safety plan. There was no mention of this on the Video Review Form and no evidence of additional discussion about when a youth's behavior warrants physical intervention.

2. The Length of a Restraint and the Role of Medical Services

Regarding Restraint Packets #347682 and #318380, the lengths of time in restraints were not identified as concerns in the Facility Administrator's reviews. See the comments for Paragraph 41a regarding the implications of protracted restraints. Additionally, the video from Restraint Packet #341283 showed two nurses in the dayroom during these restraints. It is difficult to tell what the nurses were doing and whether they were participating in the restraint in indirect ways. For clarification, the National Commission on Correctional Health Care does not support the use of nursing staff to

supplement security staff functions. Issues about the length of restraint, implications for the supervision of the restraint, and the role of health care staff when on-site during the restraint should be identified in the Facility Administrator's review, particularly when the circumstances would support Documented Instruction or coaching.

3. Protocols for Situations where Youth Have Released Themselves from a CPM Hold.

Regarding Restraint Packet #341280, the youth broke away from a staff restraint (see the above discussion for Restraint Packet 341280), and the question is if and how the restraint continues from this point. This issue was not addressed in the Restraint Monitor's report or in the Facility Administrator's review. Documented Instruction and coaching could be helpful for the YDA to determine alternative de-escalation strategies that can prevent the re-engagement of the restraint.

4. The Quality Assurance Report Recommendations

The QAI Report recommended measures to enhance referrals for Documented Instruction. This included measures that provide for the Reportable Incident Reports (RIRs) being called in within the two-hour period required by agency policy. QAI recommended that there should be consideration of staff feedback regarding Documented Instruction. Facility Administration should have access to determine whether staff felt there was a benefit to the DI they received. This would require consideration from Home Office.

Echoing the sentiments in the lead paragraph, the Facility Administrator's review provides a "check and balance" on CPM, allowing each facility to analyze the implementation of the restraint process based on actual events and to implement and create educational responses that enable staff to enhance their skills and abilities. One likely outcome is an adjustment to the CPM strategies as more information becomes available about how staff implement it. The review of these Restraint Packets and their videos prompts new issues regarding restraints and the relationship with the Settlement Agreement. Applying the concept of a chain analysis (the assumption that complex behaviors chain or have a sequential characteristic), this administrative review process should expand its analysis of de-escalation or the ability of staff to disrupt the chain before it gets to a physical intervention. When a pre-restraint problem results from staff escalation and a restraint follows, the restraint is an inappropriate use of force. If an inappropriate provocation by staff results in a technically perfect restraint, it should be categorized as an unnecessary restraint or an excessive use of force and referred for Documented Instruction.

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

the method. Supervisor staff who are routinely involved in responding to incidents and altercations shall be trained to evaluate their subordinates' uses of force and must provide evaluation of the staff's proper use of these methods in their reports addressing use of force incidents.

COMPLIANCE

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

Teamwork appears to be a training concern for Taberg. The need to assimilate and mature many of the new staff depends upon teamwork, team meetings, and team strategies to enhance program consistency especially as it applies to the structure needed to support safety and security. Currently, there are too many deviations in the schedules, rules, and program norms, which administration and staff said contributes to the high numbers of restraints.

These are operational questions that relate to the practical application of the New York Model in conjunction with CPM. One staff member, who was identified as "effective" by both youth and staff, suggested the need for an additional team meeting that focused on the application of the New York Model from the perspective of the YDA. The concern was about how to integrate the New York Model principles more effectively in daily living situations. The staff member's primary concern appeared to be increased effectiveness with the de-escalation and prevention of problems. It would be better for Taberg staff to consider the regular implementation of meetings for YDA staff to discuss with youth counselors, AOD's, and treatment staff ways to handle or respond to youth behavior that is both consistent with the New York Model and consistent across staff.

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.12); the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. All staff confirmed with acceptable accuracy the call for assistance procedures based on the color code indicators, where Code Yellow = personal safety, Code Blue = medical, Code Green = security, Code Gray = mental health issues, and Code White = restraint in progress.

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

COMPLIANCE

COMMENT: 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 Central Services Unit (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: The monitoring visit included a complete review of the Red Book, reviewed and updated on August 6th, 2012.

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

COMPLIANCE

COMMENT: The policies and procedures referenced in paragraphs 41-43 are addressed primarily in policies 3247.12 and 3246.02. These policies are part of the CPM training, and the STARS system confirms the Taberg staff's successful completion of the training.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). Most of the comments below reflect aspects of the current reporting and investigative process as they relate to the responsibilities of the individual facility staff.

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

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

COMMENT: At the beginning of the monitoring visit, Taberg administration informed the Monitors of a suicide attempt on the previous evening in Bathroom 2 on Unit 12. The walkthrough of the facility included a special stop at Bathroom 2 in order to see the location of the youth's suicide attempt. It was noted that the bathroom windows were covered on the inside with paper towels. Because the bathrooms exist as potential suicide hazards related to fixtures and plumbing, they have been a point of safety concerns by the PH Monitor. The previous Taberg report stated,

> All of the bathroom door windows on Unit 12 were covered on the inside with paper towels. Due to concerns about possible suicide risks associated with the bathrooms, the policy regarding the removal of items on the bathroom windows that obstruct vision needs to be enforced.

At the end of the visit, Taberg administration had responded quickly and appropriately, and maintenance had created and installed a barrier to prevent youth from looping clothing or other ligature materials around this small, exposed section of pipe. However, the continued obstruction of the view into the bathrooms is contrary to the intent of this Paragraph regarding the OCFS commitment to address all supervisory issues related to suicide attempts.

To this end, the State shall:

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: The review of SIU reports suggested compliance with this paragraph.

44. c. Create or modify and implement policies, procedures, and practices to require that a nurse or other health care provider will question, outside the hearing of other staff or youth, each youth who reports to the infirmary with an injury regarding the cause of

the injury. If, in the course of the youth's infirmary visit, a health care provider suspects staff-on-youth abuse, the health care provider shall immediately take all appropriate steps to preserve evidence of the injury, report the suspected abuse to the Statewide Central Register of Child Abuse and Maltreatment ("SCR"), document adequately the matter in the youth's medical record, and complete an incident report.

COMPLIANCE

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

In general, the PRE procedure has been applied effectively and consistently in the DOJ facilities. During each monitoring visit, the PH Monitor asks a nurse to explain and demonstrate the process for ensuring confidentiality during the PRE. Taberg clinical staff gave an excellent demonstration that included (a) the nurse's asking the YDA that accompanied the youth to the clinic if he/she had been directly involved in the restraint, (b) turning on a radio to a pre-set station and volume to create background noise, (c) instructing the YDA staff member where to stand in the clinic office, (d) closing the door to the exam room within six inches of being shut, and (e) eliminating all sight lines into the exam room.

Concerns remain about the documentation in the progress notes of a PRE that does not occur in the clinic. In some instances, the PRE has occurred on the Unit or in the classroom, and the documentation has not consistently described the circumstances surrounding the non-clinic PRE related to confidentiality. In other words, the documentation has been insufficient to confirm that confidentiality occurred. It is also important to note that no youth complained about the lack of confidentiality with any PRE. The issue here is improved documentation of the PRE that occurs outside the clinic.

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

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

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

PARTIAL COMPLIANCE

COMMENT: The Special Investigations Unit conducts investigations, and the reviews of SIU investigations have revealed careful and thorough investigations, completed in a generally timely fashion. However, as the implications of the Settlement Agreement play out in the daily practice in the DOJ facilities, difference may exist regarding the nature and timeliness of the investigations. For example, of the 25 Taberg investigations reviewed by QAI, 15 (60%) were still open. Eleven investigations with dates ranging from January 1 through April 2012 were outside the 60 day investigatory window.

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

PARTIAL COMPLIANCE

COMMENT: The disciplinary procedures that evolved from Article 33.3 of the Agreement between the State and CSEA for the Institutional Services Unit are often difficult to understand. In response, the PH Monitor selected personnel documents to see if they comport with the Paragraph 44e requirements for a prompt and appropriate corrective action. The Taberg visit generated a request for personnel information about two YDA employees. Both were involved in the same incident on April 2, 2012, and, following investigations, both received a Notice of Discipline (NOD) between 3 to 3 ½ months following the event. Hence, both personnel actions reflected an improvement of timeliness when compared to previous examples.

YDA 1 was found guilty of (a) failure to seek and wait for assistance prior to initiating a physical restraint, (b) failure to protect a youth from mistreatment by YDA 2, (c) failure to notify supervisors of the improper actions of YDA 2, and (d) giving false, misleading, or incomplete statements on an Incident Report (official document) and lying about the misbehavior of YDA 2. The NOD proposed that YDA 1 receive a Formal Letter of Reprimand and a penalty of a 6-month suspension. Even though other juvenile correctional agencies might have found the severity of this misconduct sufficient to warrant termination of employment, a 6-month suspension without pay appears to be acceptable. However, there was no paperwork to indicate that further action had been taken regarding the implementation of the suspension, and there was no documentation to indicate whether the suspension was with or without pay. Therefore, any assessment of the appropriateness of this action is pending further information because the disciplinary proceedings were not yet resolved.

Regarding YDA 2, the Notice of Discipline proposed termination of employment based on having been guilty of misconduct that included (a) failure to seek and wait for assistance prior to a physical restraint on a youth, (b) escalating the resident's behavior and impeding the non-physical de-escalation process, (c) using inappropriate, unnecessary, and excessive force by kicking the youth, (d) using inappropriate, unnecessary, and excessive force by using full body weight on the youth during the restraint, (e) spitting on the resident during the restraint, and (f) failing to use the minimum amount of force necessary to stabilize the situation. Termination of employment seemed highly appropriate. However, the paperwork supplied to YDA 2 indicated a suspension without

pay effective on July 23, 2012 but was changed to July 30, 2012. Paperwork also indicated that YDA 2 could use accruals, which might explain the two dates for the initiation of the suspension. If YDA 2 chose to use accruals, the suspension would begin on July 23, 2012, but if not, the suspension would begin on July 30, 2012. The paperwork also indicates that the decision about the accruals was not made until August 16, 2012. Documentation regarding the outcome of the termination effort has not been provided. Therefore, an evaluation of the appropriateness of this action is pending.

The Home Office has been consistently responsive to requests for clarification about personnel matters, disciplinary action, and the requirements of the collective bargaining agreement. There have been some noted improvements in the timing of certain actions, specifically the Notice of Discipline. The Home Office explanations have added some clarity to an otherwise complicated approach to corrective actions.

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

COMPLIANCE

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

The Daily Achievement System (DAS) was a concern regarding program consistency and, therefore, might require more training, or coaching, or both. Staff described questions about how to grade a youth's behaviors. There was some disagreement about how to supply some type of sanction for minor misbehaviors while simultaneously encouraging youth when they worked through the problems using strategies identified by the New York Model.

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

COMPLIANCE

COMMENT: At the facility level, there were no concerns expressed by YDA staff or supervisors about the adequacy of staff supervision of current Taberg staff. However, the concerns discussed in Paragraph 41a have supervisory implications regarding the safety of youth in a protracted restraint that need to be included in the Home Office review of length of restraint and supervision.

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.

COMMENT: These factors are mostly systemic and apply to Home Office.

III. MENTAL HEALTH MONITORING

An impressive amount of work on policies and New York Model training materials has occurred in recent months. The 6/12 OCFS six-month progress report indicated that almost all the activities in the original compliance plan have been completed. For the ten mental health paragraphs of the Settlement Agreement, two policies have not been finalized (new policy on Facility Admission Process, and an update on the integration of PPM 3443.00 "Resident Rules" in the New York Model), one training curriculum has not been completed (and protocols related to developing uniform working diagnoses for mental health professionals), and standards for substance abuse treatment are being developed. The MH Monitor cannot fully assess compliance until the policies are finalized, staff are trained using new curricula and the staff demonstration of consistent application of the training and adherence to the policies can be observed.

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

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

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

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

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

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

PARTIAL COMPLIANCE

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

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

The Mental Health Rounds and support teams (formerly treatment teams) descriptions in the New York Model training materials have been improved. Through support teams and Mental Health Rounds, Taberg staff are complying with 46c.

The Daily Achievement System description in the New York Model training materials has been improved, complies with the requirements of 46d, and is being implemented at Taberg.

The IIP description in the New York Model training materials has been improved, complies with the Settlement Agreement, and is being implemented at Taberg.

The trainer at Taberg is providing New York Model training. Most of the Taberg staff attended all nine modules of New York Model training, and training is scheduled for the remainder.

The policy 2801.00 "Training Requirements for DJJOY Staff" does not mention the New York Model, Sanctuary, or DBT. While some of the required training topics in the policy comply with the Settlement Agreement, it is the New York Model training—which includes the integrated assessment, the support plan (formerly treatment plan), and how to utilize both in support teams (formerly treatment teams)—that is more important for compliance with paragraph 46.

The MH Monitor reviewed the curriculum for direct care staff entitled "Mental Health for DJJOY Youth: Disorders, Interventions and Management Basics" which complies with the Settlement Agreement. A single all-day training (which also included Psychiatric Medication training) is too much mental health information to digest. Re-designing this training for a series of shorter sessions that use examples from the population familiar to staff, as done at Columbia, is recommended.

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46a and b. These remedial measures are implemented at all four facilities with the New York Model, including implementation guidelines for treatment teams, facility rounds, phase advancement, individual intervention plans, youth orientation, and mentor program. Each facility will continue to receive implementation guidance and support from the Bureau of Behavioral Health Services. The requirements for behavioral treatment are outlined in the Behavioral Health Services policy (PPM 3243.33). Facility staff were provided orientation on the Behavioral Health Services policy. The requirement for mental health staff to provide regular consultation is part of the New York Model curriculum and is also discussed in the Behavioral Health Services policy (PPM 3243.33).

46c. This remedial measure is implemented at all four facilities. The requirement to regularly assess the interventions utilized is part of the New York Model curriculum and the integrated support team process. Oversight of this process and clinical supervision are discussed in the Behavioral Health Services policy (PPM 3243.33).

46d. This remedial measure is partially implemented. Each of the four facilities has a manual and documentation to provide orientation to youth on the New York Model. The current Resident Rules are posted for youth to see. However, the Resident Rules policy (PPM 3443.00) is being revised for consistency with New York Model, and these revisions

are not yet finalized and have not been sent to DOJ for approval. OCFS requested an extension to 12/19/12 for the Facility Admission and Orientation policy.

On Site Observations (8/12)

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

The New York Model has been described extensively in prior monitoring reports and will not be summarized in this report. Achieving trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet girls' needs is difficult with a population as challenging as the Taberg girls. Using the New York model, Taberg staff are working to improve their responsiveness to the needs of the girls, such as: to be treated respectfully, to have some control over what happens to them, to be praised, to calm themselves, to be less reactive to threat, to express anxiety, fear and anger safely, to compensate for their disabilities, to feel their family and culture are valued, and to have trusting relationships.

The MH Monitor observed IIPs (Individual Intervention Plans) in all the reviewed records of Taberg girls. Taberg staff had recently updated many of the IIPs and now have an additional notebook of all the girls' IIPs in the AOD's office. IIPs are more likely to be effective when they fit the individual and use her words. Some IIPs are almost identical ("Offer Time Away," "Distract by talking," "Isolate") as are some Safety Plans ("Time Away," "Journaling," "Think about going home"). "Talk to me before I go off," "Hold my stuffed bunny," and "Tell myself I have self-control" sound more like the girls' voices. Instead of "Remind her to use her safety plan," it would be more effective for the IIP to incorporate the details of that girl's safety plan (for example, "Remind her to hold her stuffed bunny to soothe herself" or "Remind her to write a letter to her sister to calm down"). Instead of "Think about going home," it would be more effective for the girl to specify in her IIP something she is looking forward to at home. In addition, since so many girls are having difficulty learning to accept 'No" without feeling rejected or victimized, should there be consideration of adding to safety plans a specific response that may be more effective for that particular provocation than Time Away or Not Having an Audience? IIPs are designed to be changing documents, and when the first one is written a girl has just arrived at Taberg and may not understand what she is being asked about, but as she learns new skills she can refine her IIP in her own words.

The Daily Achievement System (DAS) is another New York Model component that meets the requirements of the Settlement Agreement. The BBHS Chief of Treatment Services guided the Taberg administration and coaches on how to score the DAS and discuss it with girls. Coaching is ongoing on how to use the DAS as a behavior management tool and learning not to reinforce negative behavior (which undermines the DAS). Since the implementation of the DAS, the Taberg Assistant Director has improved the incentives and is continuing to do so. The Taberg coaches are working with the BBHS Chief of Treatment Services on integrating the DAS into the disciplinary system, and in September

the New York Model Phase system will be implemented. The Taberg DAS is scored daily during five periods: 6-10 PM, 10 PM-6AM, 6-10AM, 10AM-2PM, and 2-6PM and is organized into the same five sections as the Columbia DAS, but the content is different.

Demonstrates Safety: Non-violent/Follows program rules and norms
- Wears Safety Plan
- Attends school, group, meals
- Seeks help from staff to remain safe
- No physical aggression or horseplay
- No kicking, punching, breaking objects, throwing food, spitting
- No verbal threats

Manages Emotions: Uses skills to avoid conflicts or problems
- Responds to coaching from staff in a crisis situation
- Uses skills to manage emotions (ART, problem solving, DBT skills)
- No verbal threats, racial slurs, swearing, inappropriate sexual language
- Participates in community meetings

Deals with Loss: Accepts circumstances
- Accepts responsibility for behavior
- Accepts being told "no" or having to wait
- Does not engage in blaming others

Works toward the Future: Plans for the future
- Attends school daily; is not disruptive in class
- Participates in community meetings—engages in goal setting
- Attends group sessions

Shows Effort: Beyond simple compliance with program; is active, not passive
- Raises hand and asks questions
- Completes assignments
- Volunteers for tasks

It is commendable that the DAS has been implemented at Taberg with benefits already in girls' behavior. Refinements in the DAS could include redesigning the Shows Effort portion to reflect a girl's individual treatment goals, strengthening the Works toward the Future section to focus on positive behaviors that will be successful in the community, and in the other three sections avoiding rule compliance and instead reframing the achievements in specific, positive terms that incorporate the coping skills taught in the New York Model.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Taberg coaching team includes the BBHS Chief of Treatment Services who is now assigned to support them weekly. Unlike other facilities, Taberg did not have New York Model implementation training; the population could not be lowered for large groups of staff to go to training. Consequently, Taberg's incremental implementation of components of the New York Model has not been as philosophy-driven as desirable. Coaching has to bring the philosophy behind the New York Model into daily operations, as the Taberg coaches said: "The training taught staff what to do and now the coaching supports them in how to do it." They point out that it is positive that Taberg has so many more staff, but they "feel like we are always catching up."

Keys to coaching are appreciating how staff feel, demonstrating how to use the New York Model in responding to a resident, and recognizing improved practice. It is essential that the coaches are out on the unit much of time in order to coach. Three of the coaches are new clinicians who are still earning the trust of staff.

Helping all staff teach self-calming is the coaches' primary activity. Staff are learning to be more patient and to respond early to a girl rather than reacting as she escalates. As a result, there are fewer restraints. Engaging girls with such high emotional needs is challenging, and the coaches help staff use a girl's IIP to support her in soothing herself. The coaches go to shift briefings where they guide how to use the DAS to give feedback to a resident, emphasizing that tomorrow can be different. Coaching also provides support for staff to avoid getting angry, defensive, or controlling, engage in power struggles or take girls' behavior personally. A restraint during the site visit was an example of excellent calming by an YC, using a quiet voice and careful words to help a girl regulate her emotions. Coaching on the use of the same technique before she became so agitated and was restrained was necessary.

An important part of the shift in philosophy with the New York model is an emphasis on giving recognition to staff for their accomplishments. Every time a girl calms herself, uses her safety plan and her skills, avoids a restraint, or recovers quickly and has a shorter restraint, both the girl and the staff who made it possible deserve recognition.

The Monitors discussed with the QAI Director and the BBHS Chief of Treatment Services analyzing the type of restraint and length of restraint data for each individual youth to note trends during her stay as a progress indicator. It is difficult to interpret the restraint records for two girls discussed later in this report. In the five months since she arrived on the mental health unit at Taberg, 15-year old SM had eight restraints, ranging in type and length with no apparent pattern:

3/29/12 23 min Supine (SM's IIP indicated she should not have supine restraints]
4/20/12 7 min Seated
5/12/12 1 min Escort-team
5/13/12 3 min Standing-single
5/18/12 3 min Standing-team; handcuffs
6/20/12 2 min Supine; standing-single
7/17/12 10 min Supine; standing-single; seated; escort-single
8/13/12 6 min Seated

In the 3 1/2 months since she arrived on the generic unit at Taberg, 15-year old LN had eight restraints, ranging in type and length with no supine restraints and all less than 5 minutes since mid-June:

6/17/12 1 min Standing-single
6/18/12 44 min Standing-team; standing-single; seated; handcuffs; escort-team; escort-single
6/18/12 5 min Protective hold
6/18/12 3 min Protective hold
7/22/12 2 min Standing-single; escort-single
7/23/12 3 min Standing-single; seated

8/4/12 5 min Standing-single; escort-single
8/16/12 4 min Standing-single; seated

In addition, if restraints occur in regular cycles at Taberg, another intervention that might be considered is for nurses to chart menses when they do weekly weight checks and teach girls about preventing premenstrual symptoms through diet and exercise.

A significant challenge for New York Model implementation at Taberg is that release is not earned by progress in achieving goals and learning skills. It is recommended that as part of the implementation of the New York Model the Home Office re-examine the fixed short length of stay even when residents do not make change that translates into enduring success in the community.

The MH Monitor observed Mental Health Rounds at Taberg, which were impressive for the depth of information conveyed and the use of Mental Health Rounds for coordination, yet still covering all the girls on a unit. In this way, everyone gets updated weekly on new developments for each girl and a girl having particular difficulty can be discussed at greater length. The psychiatrist for the unit, Assistant Director for Treatment, therapists, YC, substance abuse counselor, nurse, and BBHS Director of Treatment Services (the teachers were off for summer vacation and because of training, no YDAs were available) attended Mental Health Rounds. The QAI Review recommended multidisciplinary staff attendance, broader, consistent dissemination of information from Mental Health Rounds to staff and noting Mental Health Rounds discussion of a resident in that resident's record. The MH Monitor recommends that rather than relying on IQ scores, Mental Health Rounds discussions encourage more detailed examination of each girl's unique disabilities and how her cognitive impairments affect her on the unit, in group and individual treatment and in school.

The Sanctuary group the MH Monitor observed at Taberg was skillfully led by the YC—girls were invited into the discussion and there was strong YDA involvement. The topic was making change, and two girls talked about recent personal changes they had made. The messages girls left with were that change is difficult, but how we look at change can make it more possible. The YC was frustrated that girls with high anxiety did not speak up in the group because of the presence of observers.

FUTURE MONITORING

When they are available, the MH Monitor will review:

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

The MH Monitor will review revisions in the IIP form making it more consistent with the integrated assessment and support plan in the New York Model when they are completed.

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

The MH Monitor will observe New York Model coaching and the continued implementation of successful Mental Health Rounds, the Daily Achievement System, IIPs, and chain analysis.

The MH Monitor will discuss with the coaching team charting restraint decreases and recovering quickly for each girl as indicators of emotional regulation and how to reinforce it through the DAS, mentoring and support team.

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

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

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

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

PARTIAL COMPLIANCE

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

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

A 2/12 email entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" complies with the Settlement Agreement and indicates that "each of the facilities report having an established procedure in place." A follow-up 3/5/12 memo from the Director of BBHS to the facility directors indicated that the AOD will contact the treating clinician for mental health crises after hours at Taberg, which complies with 47b.

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

The consistency of teaching residents self-calming and following PPM 3247.60 "Suicide Risk Reduction and Response" will be reviewed by the MH Monitor to determine full compliance.

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. The CPM manual was developed and staff were trained. Staff received a full-day comprehensive training in Mental Health and Psychiatric Medications, which includes strategies to address mental health crisis. In addition, facilities have dedicated mental health clinicians, and Home Office has a crisis response coordinator to assist with such situations. In addition to implementing the policies listed above, OCFS oriented staff in the Crisis Response and Radio Communications policy. The Individual Intervention Plans (IIPs) are in use at each facility and include specific strategies to help the youth. Staff have training and guidance in how to work with youth in mental health crises.

On Site Observations (8/12)

The MH Monitor reviewed the finalized policy 3247.60 "Suicide Risk Reduction and Response" and summarized its contents in previous monitoring reports. The MH Monitor found documentation of Personal Safety Watches in the residents' records at Taberg. A good example of this documentation was a girl on suicide watch for a week, with the clinician carefully documenting 30-45 minute weekday evaluations in which her "difficulty maintain behavioral control; still engaging in impulsive actions; and rapid changes in behavior and mood" were the reasons for continuing the watch. The last note concluded, "YDA, Medical, YC, AOD report she has been maintaining acceptable behavior and has not engaged in any threat/gestures of self-harm or harm to others. Now goal-oriented, cooperative and relaxed. She denies suicidal intent and believes she is safe and free from negative thoughts that led to the behavior resulting in suicide watch status. Discussed alternative actions to maintain safety. Suicide watch discontinued."

No Taberg resident went to a psychiatric hospital in the past six months.

FUTURE MONITORING

The MH Monitor will document that the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents. At the next site visit, the MH Monitor will meet with clinicians to discuss personal safety watches that occurred in the interim.

The MH Monitor will observe coaching of staff on calming youth, de-escalation, and chain analysis.

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

a. Create or modify and implement policies, procedures and practices to require that each youth admitted to a Facility is comprehensively

screened by a qualified mental health professional in a timely manner utilizing reliable and valid measures. The State shall require that any youth whose mental health screening indicates the possible need for mental health services receives timely, comprehensive, and appropriate assessment by a qualified mental health professional and referral when appropriate to a psychiatrist for a timely mental health evaluation.

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

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

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

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

PARTIAL COMPLIANCE

The Integrated Assessment sample in the New York Model training materials provides clarity about what should be contained in the assessment and the Integrated Assessment format complies with 48a, d, and e.

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

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

Standards for clinicians regarding consistent diagnostic practices are being developed and will be reviewed by the MH Monitor to determine full compliance.

State Report on Progress (6/21/12)

48a. This remedial measure is implemented. First, all youth arriving at Reception or any facility are initially screened by staff using OCFS 1448 Admissions Screening Interview. Youth arriving at Reception or directly at Secure Centers from detention receive an initial comprehensive mental health assessment. Within 72 hours of arrival at a facility other than reception or the initial secure facility, the youth is assigned a clinician who reviews prior mental health assessments, conducts and documents a clinical interview and screens for suicide ideation and symptoms of anxiety, depression or PTSD (OCFS revision, 9/27/12).

48b. This remedial measure is implemented in all four facilities. The procedure for referring a youth to a qualified mental health professional for evaluation is in place. The committee and procedure to transfer youth to a more appropriate setting was created. A memo outlining the procedure was re-issued 2/2/12.

48c. This remedial measure is implemented in all four facilities. The New York Model treatment team process addresses this remedial measure. In addition, the OCFS chief psychiatrist distributed psychiatric standards as well as articles on new diagnostic entities to psychiatrists. Psychiatric contact notes are shared as a regular part of communication with the treatment team. The Bureau of Behavioral Health Services offers ongoing training to professional staff.

48d. This remedial measure is implemented in all four facilities. The New York Model treatment team process and facility rounds address this remedial measure by facilitating regular communication between the psychiatrist and clinicians on each youth's working diagnosis.

48e. This remedial measure is implemented in all four facilities. All of the components listed in the remedial measure are part of the Psychiatric Evaluation form.

Review of Psychiatric Practices (3/12)

The MH Monitor's compliance review was assisted by record reviews, interviews and observations of Daphne Glindmeyer, M.D. (Board certified Child and Adolescent Psychiatrist) at a March 28 and 29, 2012 site visit; her review was at Lansing and Finger Lakes, but her findings are relevant to psychiatry practices at the four DOJ facilities. The MH Monitor adopts Dr. Glindmeyer's recommended finding that OCFS did not have current policy and procedure indicating the acceptable timeframe within which the psychiatric

assessment must be completed following referral. Generally accepted practices are that emergency evaluations must be performed within 24 hours, urgent evaluations within 72 hours, and routine evaluations within 7-10 days. Timeframes should be stated in policy and procedure, with Quality Assurance determining whether assessments are completed within the designated time period.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that psychiatric assessments and follow-up psychiatric treatment documentation was sparse, making it difficult to determine how they were utilized in clinical decision-making. In addition, in many cases clinical decision-making was hampered by the absence of prior treatment records. The full implementation of electronic medical records is designed to resolve this problem soon.

The MH Monitor adopts Dr. Glindmeyer's recommended finding regarding the lack of diagnostic concordance between psychiatry and the other clinicians. She found that case formulations determining how specific diagnoses were made were lacking, so some psychiatric assessments noted symptoms on a checklist, but a diagnosis with no relation to the symptoms designated was assigned. Youth with significant substance abuse disorders did not have any recognition of substance abuse in the diagnoses assigned by psychiatry.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that although the OCFS Chief of Psychiatry developed a format for psychiatric assessments that was updated 2/27/12, the psychiatric assessments reviewed were not consistent with generally accepted standards. They lacked detail, over-relied on checklists, and did not include appropriate case formulations or treatment recommendations. A psychiatric medication management progress note should document symptoms, response to treatment (or the lack thereof), treatment plan recommendations, and the youth's physical condition including weight, vital signs, and laboratory. The psychiatric review may include some checklist items for the mental status examination, but the psychiatrist should write about the youth's individual response to medication or other issues.

On Site Observations (8/12)

The Taberg staff are using the Integrated Assessment.

At Taberg, the psychiatrists saw many residents weekly.

The diagnoses of DJJOY youth treated with psychiatric medicine were recently reported:

- 42% of youth treated with psychiatric medicine are being treated for mood disorders such as: Major depression, Mood disorder NOS, and Bipolar disorder.
- 21% of youth treated with psychiatric medicine are being treated for disorders of attention and activity such as: ADD and ADHD.
- 17% of youth treated with psychiatric medicine are being treated for disorders of sleep.
- 9% of youth treated with psychiatric medicine are being treated for anxiety disorders such as: Post Traumatic Stress Disorder (PTSD), Generalized anxiety disorder, and Obsessive-compulsive disorder.

- 5% of youth treated with psychiatric medicine are being treated for disruptive behavior disorders such as: Conduct disorder, Oppositional defiant disorder, and Disruptive behavior disorder.
- 4% of youth treated with psychiatric medicine are being treated for psychotic disorders.
- 2% of youth treated with psychiatric medicine are being treated for impulse control disorders such as: Intermittent explosive disorder and Impulse control disorder.

Since the last monitoring visit, the Psychiatrist Contact Form had been improved. The addition of "Interim History" at the top of the form provides a place for the psychiatrist to report on his/her discussion with the resident. Some of the Psychiatric Contact Notes at Taberg were excellent: the symptom checklist was completed, the psychiatrist noted the resident's concerns and his/her response, vital signs and side effects were noted, and changes in diagnosis and medication could be followed from contact to contact; Abnormal Involuntary Movement Scale results were reported. For residents complaining of sleep problems, the psychiatrist requested that staff complete a sleep log that the psychiatrist discussed with the resident to determine whether sleep medication was warranted.

If the Integrated Assessment and/or support plan has a different diagnosis than the psychiatrist's diagnosis, agreement must be arrived at about a diagnostic formulation through a collaborative process of considering the resident's history, the basis for the psychiatrist's conclusions, and the basis for the other clinician's conclusions. Youth must have diagnoses based on the presence or absence of specific symptoms and symptoms must meet criteria for the diagnosis. These collaborative case formulations should be documented in the Integrated Assessment initially or in a later addendum. The target symptoms necessitating treatment with psychiatric medication must be documented in order to determine to efficacy of medication. In one of the records reviewed at Taberg, the diagnostic formulation was concerning. The 15-year old resident with a trauma history arrived from Lansing prescribed Abilify and was seen by the Taberg psychiatrist three weeks later who noted "denies psychiatric symptoms, not sure why prescribed medication." A week later the Psychiatric Contact Note checked no symptoms on the symptom checklist and concluded with diagnoses of Rule out Conduct Disorder, Rule out Mood Disorder, Rule out ADHD. A week later the same diagnoses were given, and Abilify, Fluoxetine and Trazodone were continued but Concerta was discontinued because of decreased appetite and steady weight loss. At the fourth psychiatric visit, she was described as stable but frightened by the highly dysregulated behavior of other girls on the unit, the diagnosis was changed to Rule out Conduct Disorder, the three medications were continued, and nothing was indicated on the symptom checklist except sleep problems.

The OCFS Chief Psychiatrist indicated that she composed the Psychiatric Diagnostic Evaluation and Psychiatrist Contact forms after consultation with colleagues elsewhere. Scales assessing anxiety, depression and ADHD were recommended to psychiatrists because of their good psychometric properties. All of this diagnostic and treatment documentation is placed in JJIS where it is accessible to clinicians, medical staff, and administrative staff. The psychiatrists also read the BBHS contact notes prior to seeing the

resident in order to see what has transpired since the last visit. A psychiatric evaluation is performed upon entrance to a facility if one has not been done within the prior 6 months within OCFS. If an evaluation has been performed within this time period, the psychiatrist can either do another or complete a Psychiatrist Contact Form at the time of the youth's first visit to the psychiatrist at the new facility.

OCFS indicated that clinical staff are instructed to discuss diagnostic issues with the psychiatrist and other mental health (including substance abuse) staff to reach a consensus diagnosis encompassing all of the available clinical data. This may occur in Mental Health Rounds or Red Flag meetings, "but might be via a spontaneous consultation between the clinicians. A consensus working diagnosis is reached at the first support team meeting 30 days after arrival of the youth to the facility. If the psychiatrist is not present at the support team meeting, then his/her diagnostic notes are presented by the clinician. The working diagnosis is updated as necessary at subsequent support team meetings. At the last support team meeting, the discharge diagnosis will be reached by consensus. The diagnosis and support team plan are both being built into JJIS. Staff currently scan the psychiatric evaluation and attach it to the youth's record in JJIS."

FUTURE MONITORING

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

The MH Monitor will review protocols for mental health professionals on developing uniform working diagnoses.

The MH Monitor will discuss consistency in diagnostic practices with the clinicians.

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

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

b. Create or modify and implement policies, procedures and practices for the routine monitoring of psychotropic medications, including: establishing medication-specific standards and schedules for laboratory examinations; monitoring appropriately for common and/or serious side effects, including requiring that staff responsible for medication administration regularly ask youth about side effects they may be experiencing and document responses; establishing protocols for timely

identification, reporting, data analyses and follow up remedial action regarding adverse drug reactions; monitoring for effectiveness against clearly identified target symptoms and time frames; requiring that such medications are used on a time-limited, short-term basis where such use is appropriate, and not as a substitute for adequate treatment of the underlying cause of the youth's distress; requiring that youth are not inhibited from meaningfully participating in treatment, rehabilitation or enrichment and educational services as a result of excessive sedation; and establishing protocols for reviewing such policies and procedures to require that they remain consistent with generally accepted professional standards.

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

PARTIAL COMPLIANCE

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

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

The MH Monitor reviewed the training curriculum required by the Settlement Agreement entitled "Introduction to Psychiatric Medicine" which is designed to inform direct care staff at DJJOY facilities about the principles of psychiatric treatment with medication and the side effects and complications that may occur with psychiatric medicines.

Consistency of connecting medication to diagnosis and tailoring medication to each resident's symptoms will be reviewed by the MH Monitor to determine full compliance.

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received orientations on the Psychiatric Medications and Behavioral Health Services policies. Psychiatrists have been provided instruction and forms have been distributed to track psychotropic medication prescription and monitoring. The Standard Psychiatric Evaluation form covers the documentation required in the remedial measure. Psychiatrists are required to enter psychiatric contact notes into the Juvenile Justice Information System (JJIS). A more targeted and specific procedure for psychiatric standards and guidelines is in development and will be provided to health professionals this year. Orientations for nurses on psychiatric medications monitoring are in progress; these are expected to be completed before the end of June 2012.

Review of Psychiatric Practices (3/12)

The MH Monitor's compliance review was assisted by record reviews, interviews and observations of Daphne Glindmeyer, M.D. (Board certified Child and Adolescent Psychiatrist) at a March 28 and 29, 2012 site visit; her review was at Lansing and Finger Lakes, but her findings are relevant to psychiatry practices at the four DOJ facilities.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that in the cases she reviewed medication dosages were not excessive and there was not evidence of polypharmacy (the prescription of two or more medications from the same class or three or more medications from any class). When youth are prescribed three medications, the rationale for polypharmacy must be documented. Generally accepted practices require that therapeutic levels of specific medications are obtained within a period of time (generally two weeks) following the start of a medication, within a period of time (generally two weeks) following a dosage increase, and then periodically (every three to six months) during continuing treatment. Abnormal involuntary movement scale monitoring should occur prior to the prescription of antipsychotic medications and then regularly at intervals of three to six months. Individuals prescribed Seroquel are at increased risk for the development of cataracts, and an annual eye examination is recommended. Use of Depakote in female youth before the age of 18 years has been associated with an increased risk of polycystic ovarian syndrome and consultation with a gynecologist is advisable. [Note The OCFS Chief Psychiatrist disagreed with Dr. Glindmeyer that these steps are the standard of care for youth prescribed Seroquel or Depakote]. Dr. Glindmeyer found that appropriate laboratory examinations were present in the youth records, but in many cases psychiatric documentation was inadequate to determine review of the laboratory results or the use of the results in clinical decision-making. Laboratory parameters must be reviewed regularly as new medical information on monitoring specific side effects becomes available. Policy should include the requirement for frequent review and revision of the laboratory parameters. Policy requires that adverse drug reactions are reported to the Chief Psychiatrist and the Medical Director. There are certain adverse drug reactions that are reportable to the Food and Drug Administration. Quality Assurance monitoring, which could also include peer review, could monitor compliance with these laboratory practices.

On Site Observations (8/12)

Sixteen of the Taberg girls have psychiatric diagnoses: Mood Disorder, Conduct Disorder, Depression, Anxiety, Bipolar, and Impulsivity. Sixteen of the girls were prescribed psychiatric medication, and 8 take more than one psychiatric medication: Seroquel (7), Abilify (4), Zoloft (3), Trazodone (2), Prozac (2), Depakote (2), Remeron (2), Lithium (1), Lexapro (1), Clonidine (1), Clozapine (1), and Cogentin (1). The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at Taberg. The psychiatrist discussed medication in Mental Health Rounds.

Dr. Glindmeyer concurred with the MH Monitor's previous conclusion that meeting with the psychiatrist and their therapist together is often helpful for youth and informative for the clinicians about more than symptoms, medication, and side effects. Psychiatrists may meet with the therapist prior to seeing the resident and the therapist may not be in the

psychiatric session with the youth; the psychiatrist may develop a therapeutic relationship with the resident that is separate from other relationships with facility staff, depending on a variety of circumstances.

An OCFS draft document requires that "the psychiatrist will use no more than three psychotropic medicines in his/her treatment of a youth. At presentation, the number of medications may be greater, but needs to be tapered to no more than three. If the psychiatrist can justify the usage of more than three medicines, then it is important to discuss this usage with the Chief Psychiatrist. The psychiatrist will use no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer. If the psychiatrist can justify the usage of more than one medicine per class, then it is important to discuss this usage with the Chief Psychiatrist." One Taberg resident was prescribed four medications (Abilify, Depakote, Seroquel and Clonidine) and two were prescribed three medications (Abilify, Trazodone and Prozac; Clozapine, Lithium and Cogentin).

The QAI Review recommended a plan for routine scheduling of laboratory tests for residents taking psychiatric medication, and reporting lab results on the Psychiatric Contact Notes. The Director of Psychiatry has developed schedules for laboratory monitoring and nursing review of medication side effects, which hopefully will be revised and implemented soon.

Dr. Glindmeyer noted that youth in juvenile correctional facilities frequently experience difficulty with sleep onset and maintenance and another sleep intervention should be used instead of psychiatric medications that have side effects. Psychiatric contact notes indicated that at least two Taberg residents were prescribed Trazodone for sleep. The MH Monitor recommends a sleep hygiene program consistent with the coping skills taught in the New York Model.

QAI found that seven out of eight Taberg youth surveyed were prescribed psychiatric medication, six of eight knew the medications they were taking and why. Four out of the eight residents knew the side effects of their medications. Three said the medication helped them feel better, three said they help them sleep, one said they help her focus, one said they made her less anxious, and one said they made her less hyper. Eight out of 11 staff surveyed by QAI said they felt competent in the knowledge they learned in the Mental Health/Psychiatric Medication training.

FUTURE MONITORING

The MH Monitor will:

- examine final practice guidelines for psychiatry
- review records at Taberg of residents prescribed psychiatric medication
- observe discussions of efficacy of medication at Mental Health Rounds and support teams at Taberg

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

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

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

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

COMPLIANCE

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received orientations on the Psychiatric Medications policy, the Behavioral Health Services policy, and the Refusal of Medical or Dental Care by Youth policy and received a full-day comprehensive training in Mental Health and Psychiatric Medications. The medical refusal forms are completed and kept in charts for psychiatrists' review.

On Site Observations (8/12)

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

The nurses have been recently trained in a one-day session entitled "Monitoring Youth Treated with Psychiatric Medicine," including Monitoring Psychiatric Medicine, Standard Assessments, Tests, and Labs, AIMS, Side Effects of Psychiatric Medicine, Serious Medical Complications of Psychiatric Medicine, and EKG; Calculating BMI and Neutrophil Counts.

FUTURE MONITORING

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

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

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

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

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

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

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

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" cover the requirements of the Settlement Agreement: refusal of medication, health professional counseling and administration of treatment over youth objection.

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

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received Orientations on the Psychiatric Medications policy and the Refusal of Medical or Dental Care by Youth policy, and received a full-day comprehensive training in Mental Health and Psychiatric Medications. All requirements of this remedial measure are in practice. The medical refusal forms are completed and kept in charts for psychiatrists' review.

On Site Observations (8/12)

The MH Monitor observed documentation in individual records when Taberg girls refused psychiatric medication. Medication refusals at Taberg seemed to be less frequent than at other facilities. The MH Monitor observed a positive relationship between the nurses and the residents at Taberg, and it seemed that girls were less often influencing each other to refuse medication, but there may be other factors involved in medication compliance at Taberg.

The QAI Review found that at Taberg there were few psychiatric medication refusals. The QAI Review commended the clear communication between the nursing staff and the psychiatrist with the Medication Refusal forms filed in the same section of the chart, so the psychiatrist can interview residents regarding their refusals and promptly order modifications (if warranted). The QAI Review recommended that the support teams (formerly treatment teams) consistently note residents' psychiatric medication refusals and that their parent be informed.

FUTURE MONITORING

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

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

COMPLIANCE

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received Orientation on the Psychiatric Medications policy, which includes informed consent procedures, and received a full-day comprehensive training in Mental Health and Psychiatric Medications.

On Site Observations (8/12)

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

FUTURE MONITORING

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

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

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

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

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

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

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

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

PARTIAL COMPLIANCE

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

"The NY Model: Treatment Team Implementation Guidelines" meets the requirements of Paragraph 53 of the Settlement Agreement. BBHS is revising the support plan (formerly treatment plan) and the integrated assessment has been revised to make them fit the New York Model. BBHS is guiding the strengthening of staff skills in identifying needs and writing goals with residents.

The MH Monitor will review the quality of support plans and the effectiveness of support teams in order to determine full compliance.

State Report on Progress (6/21/12)

53a, b, d, e, and f. These remedial measures are implemented at all four facilities. Sanctuary, the SELF (Safety, Emotions, Loss and Future) model, the Individual Intervention Plan (IIP), DBT, and the integrated treatment plan, all components of the NY Model, as well as the psychiatric evaluation, directly address this remedial measure. As part of the New York Model, the Integrated Treatment Plan and Integrated Assessment Form were completed in July 2011. The Integrated Treatment Plan includes all of the requirements in the remedial measure, which are outlined in the Behavioral Health Services policy. Integrated treatment planning is part of the New York Model program and process, and treatment team meetings are required to be held for each youth every thirty (30) days. The psychiatrist's input is included through contact notes and the psychiatric evaluation (including working diagnosis). NY Model Treatment Team Implementation Guidelines were completed in October 2011 and staff from the Bureau of Behavioral Health Services have worked with each facility to implement the new procedures and forms. The documents and forms undergo continuous evaluation and modifications based on actual experience and feedback from the Mental Health Monitor.

53c. This remedial measure is partially implemented. While youth are present for every treatment team meeting, it has not been possible to have the treating psychiatrist present at every other treatment team meeting for every youth in his/her care. OCFS intended to address this measure with increased psychiatrist availability, and received approval to hire full time psychiatrists at each facility. However, recruitment remains a challenge. Currently, psychiatrists are available at each location only part time, and their limited number of hours prevents them from attending treatment team meetings. To meet the spirit of this remedial measure, OCFS has taken steps to include the psychiatrist's input at the treatment team meetings by using their contact notes, and to generally increase communication between the psychiatrist and clinicians during facility rounds and other informal communication. The State has requested an extension until December 19, 2012 to give time to discuss this remedial measure with the Department of Justice and the Monitors.

On Site Observations (8/12)

The New York Model approach to support teams (formerly treatment teams) is being newly practiced at Taberg and is effective with girls and families. The MH Monitor observed four support teams at Taberg, and two are described here as examples of New York Model practice that is improving:

AF is a 17-year old from Queens at Taberg on the generic unit since 5/12 for violating probation by possessing a weapon. She lived with her mother and [redacted] siblings; she had a conflicted relationship with her mother and wanted to live with father in [redacted] but he was incarcerated for substance abuse. She ran away from a treatment foster home and was cutting school. A superficial court evaluation indicated a FSIQ of 84 and a diagnosis of Conduct Disorder and Parent-Child relationship problem (related to her mother's substance abuse). She was placed at [redacted] where she was diagnosed with Conduct Disorder, Panic Disorder, Obsessive Compulsive Disorder, Generalized Anxiety Disorder and was taking Prozac and Trazodone. When she arrived the

Taberg psychiatrist noted she was depressed, having panic attacks and felt picked on. Her Integrated Assessment (7/31/12) described her as smart, empathic and wanting to change. She said her mother physically and emotionally abused her; her mother said she was defiant, violated curfew, and had poor school attendance. She was diagnosed with Major Depression and Conduct Disorder and prescribed Abilify, Prozac and Trazodone. Her 7/31/12 Support Plan (formerly treatment plan) reported excellent progress in therapy, especially reducing anger; progress in positive behavior in school and avoiding peer negativity; participation in group and individual counseling with her YC; and success with her safety plan and learning to use skills to prevent escalation. Two goals that appeared to be the same were listed: Goal #1: Wants to go home with mother (anger management—understanding anger triggers; ask for help and time away, and take medication). Goal #2: Go home (remain in present and cope with intense emotions including reducing "blackouts;" mother participating in treatment to help her manage anger successfully; on release, continue individual and family therapy). Her support team met a week before her scheduled return home, with her mother on the phone and her CMSO worker on vidoeconference; her teacher, nurse, YC, YDA-mentor (this was her first support team meeting), and the Assistant Director for Treatment (also covering for her therapist who was out) attended. When she arrived, she was enthusiastic with her mother on phone and greeted her CMSO worker. Staff each gave her positive feedback about her behavior, her school success, and her work in therapy. She seemed to have especially strong relationships with the nurse and mentor. She commented, "I've gotten so much better in school and singing. Mommy, I passed. I should be placed in 12th grade." Her teacher said, "You're the first girl at Taberg to pass a grade." She was crying and said to her team, "I made it so far. Thank you Taberg." Then she got deflated when her CMSO worker reminded her, "You have to take your Regents to graduate." Her mother asked her, "What school do you want to go to?" Her CMSO worker said her mother will have to take her to enroll and the school system will assign her to a school: "You don't have a choice." Her mother responded, "She needs to be in a school where they have things she likes." Asked about her goals, AF said, "My goals are to be with Mom and work on anger and patience. I learned patience, control anger, accepted that I'm on medication. I learned coping skills like Wise Mind. Not fighting, staying out of other people's business, have avoided crisis, no blackouts." Her mother made several supportive comments. Then AF presented her "safety plan for when I return home: Stay home; Listen to music; Ignore; Have fun; Remember I can ask Mommy, my sister, my father, and CMSO for help." The support team was exemplary for the involvement of staff who spoke directly to AF, emphasizing strengths and her goals. This last team meeting prepared her well for maintaining her gains in the community. She was clear about taking her safety plan home and her mother heard what she said and how staff supported her. Staff commented that she needed more help planning how she will advocate for herself for the school placement she wants—the findings of testing noted in the Integrated Assessment (that she was reading at the 7th grade level, doing math at the 6th grade level and was in 10th grade without special education) were not brought up as a reality when looking for a school where she could be successful despite her history of alienation from school. Furthermore, while the team helped her plan how she could achieve her goal, the question of how to manage the effects of past trauma and anger and hurt at her mother when she returns home was not brought up. In the informative Psychiatric Notes, three weeks before the support team, the

psychiatrist documented that AF was still struggling with depression, irritability, hopelessness, and worthlessness.

SM is a 15-year old from [redacted] who arrived at Taberg on [redacted] from [redacted] where the police were called nine times in the three months she was there; her offense was Criminal Mischief for breaking windows. Her diagnosis is Mood Disorder and Conduct Disorder, she is prescribed Zoloft, and she is on the mental health unit. She was removed from her mother's care as an infant and was raised by her father; she faced many difficult adjustments to her father's three partners over the past 10 years; her father now says he realizes that working long hours and leaving her with his different partners and their children was not good for her. SM's mother died in [redacted] Her first psychiatric hospitalization was shortly after her [redacted] birthday and her mother's death; she was sent to live with relatives. She reported sex abuse by [redacted] and physical abuse by [redacted]. She was hospitalized in 3/11 for assaulting her younger step-sister; she was hospitalized again in 12/11 when she attempted suicide. She was placed at Adirondack Youth Lodge, Jefferson City Children's Home, and Milton Abelove Children's Shelter, all moves due to her aggressive behavior; she was rejected from numerous treatment programs. Her diagnoses included Reactive Attachment Disorder, Oppositional Defiant Disorder, Depressive Disorder, and Speech/Language Impaired. When she was transferred from McQueen to Taberg, the notes indicated she was diabetic, obese, on 1:1 supervision for aggression and prescribed Seroquel (an antipsychotic) for mood disorder, Zoloft for depression and Intuniv for attention problems. There was no support plan (formerly treatment plan) in her record, but a support plan was prepared for the meeting. It listed her strengths as enjoys working with animals; family is supportive and willing to work with SM to improve relationship; and responsive to redirection. Her treatment goal was Anger Control: To be able to tolerate frustration without becoming emotionally dysregulated, as evidenced by her use of the DBT skill "Wise Minds ACCEPTS." Her YC was convening a New York Model support team (formerly treatment team) meeting for the first time; the Assistant Director for Treatment, YDA, three clinicians, a regional mental health representative, her CMSO and the YAP program from her county were present in person and her father was on the telephone. Her progress was described, with staff pleased she was using her safety plan and is interacting better with peers and staff. This was her 180-day support team with the goal of discussing step-down to [redacted] closer to home, which both she and her father wanted. She had one restraint and major rule violation in the past 30 days. Her goals were anger control, frustration tolerance, and family therapy. She seemed resentful that her father and his partner want more time to get ready for her return, but Taberg and CMSO staff hope [redacted] and [redacted] will work with her and her family. The support team skillfully kept her father engaged without allowing him to control the meeting. When SM entered the meeting, she said, "Be prepared for yelling because I had a restraint and he'll be mad." She said proudly she is off Abilify and has dropped Seroquel from 200 to 50 mg. The nurse said she is doing well on managing [redacted], not gaining weight, and doing more activities. Her father argued for her to be moved in time to start school year at [redacted] Her Taberg counselor wanted family therapy first. At the end of the meeting her father was pushing for Taberg to transport her for a visit in the CMSO office on a day the family was traveling to the city for dental appointments. After he got off the

phone, she angrily said she was not going to visit his partner, only her father, and hopefully team members helped her manage her anger in preparation for the visit.

Taberg staff are making progress at learning how to (a) write specific needs that can be met by all staff and (b) orchestrate the support team meeting around the resident's goals. Figuring out the unmet needs behind their behaviors to make sure each girl is an active player in getting her needs met requires a specific, needs-driven support plan explicitly connected to the skill building of the New York Model. Another Taberg resident exemplified the continuing difficulty in preparing a support plan:

MC is a 15 ½-year old from Brooklyn on the mental health unit at Taberg for 57 days for criminal mischief after having been sent to [redacted] in [redacted] for burglary and being modified for injuring another resident. Abandoned by her parents, placed in foster care at six months [redacted] she did not learn until she was a teenager that [redacted]. Her grandmother died in [redacted] and her [redacted] was killed in gang violence in [redacted]. She was aggressive toward her aunt and siblings, ran away, had altercations in 8th grade, had an IEP for learning disabilities and poor school attendance, and was involved with a physically abusive boyfriend. A court evaluation described her as hopeless, angry, irritable, moody and a victim of sex abuse. She was diagnosed with Conduct Disorder, Mood Disorder, and Cannabis Abuse. She was placed at Lansing in 12/11. She had a Lansing integrated assessment and treatment plan from 5/12 in her record, but no Taberg integrated assessment or support plan, despite arriving at Taberg in 6/12 from Lansing. A Taberg Integrated Treatment Plan was prepared for her 8/22/12 support team meeting. At the meeting she was commended for progress in her behavior, her insight regarding her feelings, asking for help from staff and volunteering to teach parts of DBT to peers in group. The diagnosis in the treatment plan was Marijuana Abuse, Conduct Disorder, Severe Mood Dysregulation, ADHD, and Phonological Disorder by history; this diagnostic formulation was not consistent with the Psychiatric Contact Notes. On the plan, her understanding of her diagnosis was left blank. Her strengths listed in the plan were: Engaged in treatment; Participates in school, counseling and mentoring. These are her accomplishments—which are important to stress—and they might lead to engagement in services in the community, but she has other strengths that can be built on in supporting her to achieve her goals, such as the particular distress tolerance skills and social skills staff said she was good at. Her goals listed in the plan were: Repair relationship with my family and earn mother's trust back; Return home to mother. Treatment goal #1 was Family Therapy: Work on trust and repairing relationship through family therapy. Treatment goal #2 was Individual Therapy: MC wants to work on prosocial skills and problem solving; CBT and DBT in individual and group therapy. These goal statements are not what was envisioned in the New York Model. The goal is To repair her relationship with her mother. The intervention is family therapy, as well as assistance her mentor and other staff provide regarding developing trusting relationships and using DBT skills. Her second goal is To be successful when she returns to her mother and the interventions are individual and group therapy to work on prosocial skills and problem solving (as well as other support from her mentor and other staff in these skills). In her support team meeting, her mother (on the phone) said, "You and I have to resolve our issues." But, at Taberg only once a month family therapy via telephone was occurring. Her mother also told her, "You have no goals. You have no plan for school or

work." This was not responded to in the meeting but was concerning given her poor grades in school and the lack of detail in the plan and past assessments about her specific learning disabilities or ADHD.

The MH Monitor observed a Red Flag meeting that included strong participation by YDAs. They discussed why a new resident had four restraints in 24 hours: "She escalates quickly and feels bullied, but does not acknowledge she instigates." The clinician warned that staff should not give her a lot of attention after a restraint, because it might be reinforcing. One YDA said fewer staff should be involved in her restraints. They talked about one restraint where a humorous event made her laugh and the restraint ended. The Red Flag meeting was an effective sharing of ideas among all staff, but it was a missed opportunity for coaching about the unique developmental needs of a 13-year old including social immaturity. While in medical, the MH Monitor observed the care an administrator took in special purchase of underwear and shoes and the nurse took in fitting shoes and bandaging the resident's foot ulcers. She showed childish pleasure in her new shoes and appreciated their care.

"OCFS Consulting Child Psychiatry Services" (2/14/12) requires that, in addition to seeing residents individually for medication management, the psychiatrist, "will attend a 1 hour weekly mental health rounds with clinicians, teacher, and representative from the on-line staff to discuss youth in his/her case load. He will attend other treatment meetings if time permits." The scarcity of psychiatric resources noted by Dr. Glindmeyer at Lansing and Finger Lakes is evident at Taberg—even though Taberg has two psychiatrists who are able to see the girls on their unit and participate in Mental Health Rounds for their unit, the psychiatrists do not have time to participate in support teams. Hopefully, OCFS is successful in its exploration of telepsychiatry, physician extenders (e.g. psychiatric nurse practitioners, physician assistants, residency/fellowship programs including possibly a consultative rotation for forensic or child/adolescent psychiatry fellows via telepsychiatry or "moonlighting" program for residents or fellows under the supervision of a board certified/board eligible child and adolescent psychiatrist), contracting with a locum tenens company, and/or the identification of a "floater" who would provide services and coverage across the system. An objective measurement should be developed of the amount of psychiatric resources necessary at each facility's maximum population level (e.g. amount of time necessary for initial evaluations, medication management, crisis intervention, Mental Health Rounds and support team meetings) and from the estimated time required, an optimal full time equivalency level should guide recruitment.

Policy sets the standard of care (e.g. youth prescribed psychiatric medication will be seen monthly to review their psychotropic medication) and timelines for the completion of psychiatric clinical activities (e.g. youth referred for an initial psychiatric evaluation will be seen within a specified time period). Then quality assurance monitoring of the treatment log could ensure that these standards were met and could guide conclusions about systemic issues such as insufficient psychiatry resources in a facility.

FUTURE MONITORING

The MH Monitor will continue to review support plans and observe support team meetings.

The MH Monitor will continue to review psychiatry coverage.

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

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

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

PARTIAL COMPLIANCE

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

The MH Monitor reviewed new materials to be used by the OCFS substance abuse counselors at the facilities. The MH Monitor had previously reviewed the curriculum for DBT for Substance Abuse training—including Structuring the Treatment Environment, Dialectical Abstinence in DBT-SUD, Chain Analysis and Task Analysis in DBT-SUD, and Working with Families in DBT-SUD.

The DBT and Substance Abuse training demonstrate progress in complying with the Settlement Agreement. The curriculum does not describe how substance abuse fits into delinquent behavior and will be treated in the New York Model (while youth live in a drug-free environment but will return to peer and family substance abuse). Like the process of becoming trauma-responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. It is crucial that support teams encourage youth confidence that they will be able to continue to use the skills learned in the facility when they return to the community so substance use does not contribute to re-offending. Substance Abuse services should be integrated into New York Model training by the BBHS Support Team providing coaching on New York Model implementation.

State Report on Progress (6/21/12)

This remedial measure is partially implemented. Regarding substance abuse prevention education, OCFS uses the curriculum Innervisions, which has recently been updated based on information from the National Institute on Drug Abuse. All four institutions will be providing this training by the end of June 2012. Regarding substance abuse treatment, OCFS created and obtained approval to hire a Substance Abuse Social Worker at each of the four facilities. Recruitment over the past two years has been a challenge. OCFS is working with OASAS to finalize standards that will guide substance abuse treatment in OCFS facilities. OCFS has selected a substance abuse treatment curriculum targeted for girls called Triad, which will be piloted at Columbia, Lansing, and Taberg this year. This curriculum is consistent with DBT and Sanctuary concepts. In addition, to facilitate integrated, trauma-informed treatment, each of the SA/SWs will be trained to address substance abuse issues through teaching DBT skills, and all clinicians will be trained to include goals around substance abuse when working with youth. OCFS requested a six-month extension to implement this remedial measure.

On Site Observations (8/12)

A new social worker is providing substance abuse services full time at Taberg. He is adapting the Triad and Innervisions programs to fit the Taberg population. He commented that when the girls hear he is a substance abuse counselor, they do not want to be part of his groups. He said they do not feel safe in groups and worry their substance abuse will be reported if they talk about it. He was interested in discussing the connection between trauma and substance abuse.

FUTURE MONITORING

The MH Monitor will review a description of chemical dependency treatment in the New York Model utilizing DBT and Sanctuary and in the context of the integrated assessment, support plan and support team process, including PPM 3243.33 and a review of the effectiveness of the Triad and Innervisions curricula at Taberg.

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

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

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

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

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

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

PARTIAL COMPLIANCE

The MH Monitor reviewed the curriculum for the one-hour training for nurses entitled "Psychiatric Medications at the Time of Release" and it explains the policy required by the Settlement Agreement: release plans for youth with a 30 days dose of psychiatric medication, an appointment with a community-based mental health program, and the involvement of the parent and CMSO case manager.

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

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

The MH Monitor will continue to review the quality of transition planning in order to determine full compliance.

State Report on Progress (6/21/12)

This remedial measure was implemented at all four facilities. Transition planning for youth with mental health needs (and all youth) is implemented. For youth with continuing mental health service needs, two forms are used: the Continuity of Care Plan, which includes specific contact information for all types of mental health service referrals and appointments, as well as current medications; and the Transition Plan, which includes more general release information such as legal contacts, housing plans, health and health insurance information, educational/vocational plans and career assessment, permanency plans, continuing support services, identification and other documents, and other safety concerns or issues. The Continuity of Care Plan has been in use since July 2011. The Transition Plan was revised in early 2012 and training on entering the Transition Plan information into JJIS was concluded at the end of May 2012.

On Site Observations (8/12)

The MH Monitor requested the Mental Health Continuity of Care plan and the Transition Plan for SP, a girl who had recently left Taberg. These had not been completed because she was transitioned to the RTF. The MH Monitor will review the Mental Health Continuity of Care plan and the Transition Plan for another recently released Taberg resident who went home.

The OCFS Mental Health/Psychiatric Medication Continuity of Care Plan contains the details of medications and the name and telephone of outpatient provider and dates of scheduled appointments, and these are not in the Transition Plan screens. OCFS indicated that "Continuity of Care Plans and Transition Plans are meant to be looked at together. Both are used; neither is meant to be a single reference point. They are completed by different staff and meant to be used together when a youth is discharged. The Continuity of Care Plan contains protected health information and as a result of HIPAA laws, it cannot be shared with everyone. The Transition Plan does not have the same restrictions. It is not OCFS' intention to combine these two forms."

The Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's community transition. However, if a purpose of the transition plan is to be a single reference point for each person involved (youth, family, OCFS staff, service providers) then it should include the telephone number and address of each person/service. Second, substance abuse recovery support services are not specifically listed. Third, the training for the plan indicated that the last section is to identify if a youth is in immediate danger of serious harm, but for all youth, their Sanctuary

safety plan could be written on the transition plan as a reminder of what the youth learned to do to calm herself (to be used in the community). Fourth, a transition plan should define how a resident's support plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last support team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Just as the youth and everyone on her team at the facility use her support plan to assess progress and refine supports, OCFS should help the youth, her family and community services be able to rely on her transition plan. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and an *integrated* transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA is necessary.

The MH Monitor has not yet reviewed an *integrated* transition plan that includes all elements of a youth's successful re-entry to the community.

FUTURE MONITORING

The MH Monitor will review transition plans of recently released residents.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

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

PENDING REVIEW

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

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

PARTIAL COMPLIANCE

COMMENT: The Monitors received the *Pilot Program Review: Taberg Residential Center for Girls* (Draft) or the QAI Report for Taberg before the monitoring visit and then had an opportunity to discuss its contents and findings before the Taberg monitoring visit.

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

For the second consecutive time, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors. For example, the QAI Report noted that the reductions in physical interventions were commendable even though more work needs to be done to continue this reduction; the staff standouts were similar to those staff identified by the Monitors; and the QAI analysis of the review of physical interventions provided an accurate understanding of the issues surrounding physical restraints.

A positive element of the monitoring process is the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitor's discussions with QAI staff members have been extremely productive. The quality of the staff and products produced by QAI predict that it will become an important component of compliance with the Settlement Agreement paragraphs. QAI has already developed a template for conducting reviews of the named facilities. Furthermore, the quality of the QAI pilot report for Taberg was excellent. The report was thorough and informative. The recommendations followed policy and procedure and were connected to the Settlement Agreement paragraphs.

QAI remains an excellent part of the monitoring process. On August 20, 2012 as part of the Taberg visit, PH Monitor met with the quality assurance staff to participate in a *de novo* review by each member of the quality assurance team of a Restraint Packet (Number 347883) based on an incident dated July 17, 2012 to demonstrate how the process works when QAI does an on-site visit. The review was set up in such a way that the PH Monitor and each QAI representative in attendance at Taberg reviewed the Restraint Packet paperwork and viewed the restraint videos to evaluate the Restraint Packet and restraint process. The event proved to be an excellent exercise in inter-rater reliability. Despite the fact that some minor differences existed in perspectives among the QAI staff, their assessments of the strengths and weaknesses of the staff behaviors in the Restraint Packet were remarkably similar. Additionally, the assessments appeared accurate, honest, and objective, avoiding any temptation to reduce the severity of staff errors based on the process being an agency function. This type of quality assurance review was impressive and could hasten the end of the Protection from Harm monitoring.

Because of the manpower available to QAI, the process appears to be more thorough and comprehensive than the current monitoring reviews of Restraint Packets. As the reliability and validity of the QAI restraint review process increases, the time is not far away when it will become the primary resource for determining unnecessary and inappropriate uses of force.

The critical and yet-to-be developed aspect of QAI will be the recommendation and approval by the Monitors of empirical compliance indicators and thresholds. The use of OCFS data will be helpful in the establishment of these indicators and thresholds.

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: The recently promulgated Implementation Standards of the Prison Rape Elimination Act (PREA) of 2003 could affect operational decisions at each DOJ facility

and, therefore, have an impact on Settlement Agreement Paragraphs. The Monitors recommended a QAI-led discussion of how PREA might relate to compliance.

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

COMMENT: No corrective actions exist as of the Taberg monitoring visit.

V. SUMMARY

Taberg has made substantial progress since the February 2012 monitoring visit. Indicators exist that the New York model is having a positive effect on both protection from harm and mental health paragraphs in the settlement agreement. Levels of safety as described by youth and staff appear to have improved, even though the ability to implement a safe environment as measured by the rate of physical restraints remains unstable.

The continued development of the Quality Assurance and Improvement Bureau represents a positive element in the movement toward compliance for all DOJ facilities. QAI conducts thorough and accurate assessments. Greater clarity on the development of specific outcomes is needed.