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

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

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INDIVIDUAL FACILITY MONITORING REPORT:

Taberg RESIDENTIAL CENTER FOR GIRLS

Taberg, NY

I. INTRODUCTION

This is the twenty-first 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 December 8-11, 2014. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

A. Facility Background Information

Taberg is a 24-bed limited secure facility for girls with two units in one building. Another building contains a gymnasium and library, and the school is in the Annex off-grounds. One unit, with 11 beds, is the only mental health unit for girls in New York State; a statewide Mental Health Unit committee does admission to that unit. The other unit, consisting of 13 beds, is the only limited secure program for girls in the state.

Taberg was a male juvenile facility, and it opened for girls on August 31, 2011 when 12 girls moved from Tryon. Staff originally came primarily from Tryon, Taberg Boys, Annsville, and Tubman; during 2012 many staff left, a large percentage were new and creating a cohesive staff team was a challenge for more than a year.

On December 9, 2014, there were 24 girls in residence at Taberg. Four were officially designated for the mental health unit. Fifteen of the girls at Taberg in December, 2014, were there during the monitoring visit in July, 2014.

The 24 girls ranged in age from 13 to 17. There were about equal numbers of 14-, 15-, and 16-year olds, with one 13-year old and four 17-year olds. The 24 girls had been at Taberg from 5 days to 326 days; this average length of stay of 4.5 months is six weeks longer than the Taberg average in previous site visits. Only five had been there two months or less, and nine (9) had been there six months or longer. Four girls on one unit were returnees to Taberg.

The 24 Taberg girls have been sentenced for: Petit Larceny (8), Assault (7), Criminal Mischief (4), Sex Abuse (1), Possession of a Weapon (1), Car theft (1), Menacing (1), and Obstructing Government (1).

Eighteen of the 24 Taberg girls have psychiatric diagnoses, and most have more than one: ADHD (1), Anxiety (3), Depression (4), Disruptive Mood Dysregulation Disorder (3), Mood Disorder (5), Panic Disorder (1), and PTSD (4); eight are diagnosed with Insomnia and two are diagnosed with Conduct Disorder.

Eighteen of the Taberg girls are prescribed psychiatric medication: Abilify (2), Benadryl (3), Celexa (2), Depakote (1), Effexor (2), Haldol (1), Lamictal (3), Lexapro (1), Prazosin (1), Prozac (3), Seroquel (2), Straterra (1), Trazodone (7), Vistaril (1), and Zoloft (3).

B. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

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

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets for the regular collection and dissemination of facility data to the Monitors. The Monitors were given OCFS' eighth Six-Month Progress Report on the Master Action Plan (MAP) on December 18, 2014.

3. Entrance and Exit Interviews

The MH Monitor was on-site at Taberg December 8, 9 and 10, 2014 and the PH Monitor was on-site December 9, 10 and 11, 2014. The entrance meeting was on December 9, 2014 and the closeout was conducted by teleconference on December 16, 2014. A complete list of attendees of the entrance interview and closeout report is available upon request.

4. Facility Tour

Walkthroughs of the facility occurred throughout the visit.

5. On-Site Review

The site visits included a review of numerous documents available at the facility and not included in the pre-visit document request list. These documents included many reports that occurred in the time between the documents prepared for the Monitors and the on-site assessments. The MH Monitor observed two support team meetings, Mental Health Rounds, a DBT group, a Sanctuary group, and a substance abuse group, met with the

TIC, met with Home Office, facility administration and clinicians/coaches, and reviewed nine (9) residents' records and listened to the other Mental Health Rounds by teleconference. The PH Monitor's direct observations included two afternoon routine activities and movement to dinner on Amethyst, two 2-person-seated restraints, two de-escalations, Crisis Prevention Management (CPM) refresher training, and the facility Therapeutic Intervention Committee (TIC).

6. Staff Interviews

The Monitors interviewed 21 Taberg staff. In addition to group meetings with staff, the MH Monitor interviewed three clinicians, a nurse, a Youth Counselor (YC), and the Assistant Director for Treatment. The PH Monitor interviewed one Facility Director, 10 Youth Division Aide (YDA) staff, the Assistant Facility Director for Treatment, the Bureau of Training trainer, one Administrator on Duty (AOD), and one nurse.

7. Resident Interviews

The MH Monitor interviewed five girls, and the PH Monitor conducted 10 interviews with Taberg girls, 6 from Amethyst, and 4 from Opal, with an average age of 14.9 years. Interviews occurred in areas with operating surveillance cameras and reasonable privacy from staff.

C. Preface to Protection from Harm and Mental Health Findings

In the December, 2014 site visit, it was evident that staff are working to return Taberg to a stable, calm environment where residents can make progress. The Taberg crisis during the spring and summer, 2014, was not about sexual misbehavior by staff toward girls. To date, every completed Justice Center sexual abuse investigation has found the allegation to be "unsubstantiated." Instead, what happened at Taberg is that false sexual abuse allegations and the unintended consequences of these unfounded allegations quickly destabilized staffing, and the structure, consistency, and order of a small facility.

The QAI Review of Taberg at the beginning of 2014 described a pre-crisis ability to resolve emotional upset and moderate uses of force while effectively calming youth. Before the sexual allegations, Taberg staff demonstrated the ability to operate within the Taberg Graduated Response System (GRS) "green" zone in December 2013 and January 2014.

The QAI Review (11/14) at Taberg concluded that many factors led to the serious disruptions at Taberg in the spring, 2014, including "the complete turnover in clinical staff, new youth at Taberg, some of whom were hyper-sexualized, and a relatively small number of youth who made multiple allegations of staff sex abuse. All investigation reports received to date have determined the allegations to be unfounded. The sheer volume of allegations, and the breadth of staff they were made against, initially proved difficult to manage operationally and emotionally. In the fall, 2014, QAI observed staff returning to practices observed before the rash of allegations began."

The situation was unique to OCFS, and possibly to all other juvenile justice communities, but the lack of prompt and adequate Home Office support at Taberg slowed the return of order, structure, and safety. Already troubled girls were further destabilized and the disrupted environment seemed to reinforce the girls' reliance on sexual abuse allegations and uses of force as ways to manipulate effectively the daily routine at Taberg.

OCFS prepared a "Multiple Sexual Allegations Response Plan" to address therapeutically future allegations of abuse, including maintaining healthy relationships among members of the facility community, thoroughly investigating the allegations and responding appropriately, and reducing the likelihood that behavioral reinforcement would cause the spread of allegations to multiple youth. Taberg's responses to the crisis are returning the facility to its stability of a year ago.

II. PROTECTION FROM HARM MONITORING

A significant change occurred at Taberg over the past 16 months, degrading safety and protection from harm factors from a point of near compliance with the Settlement Agreement to a situation that is now beginning to show signs of recovery. The changes in the conditions of confinement followed the onset in February 2014 of a rash of unsubstantiated sexual abuse allegations by youth toward staff. The disruption combined with other factors, such as the complete turnover of clinical staff, introduction of new girls, and a relatively small number of individuals who made allegations, contributed to a chaotic living condition that is only now improving.

To illustrate the point, the Monitors looked at OCFS data for the seven months preceding the onset of the staff sexual abuse allegations (July 2013 through January 2014) and looked at the same data for the nine (9) months following (February through October 2014). Included in the analysis were the GRS restraint rates, the percentage of youth involved in a restraint, the total days care, non-accidental injury, suicide events without injury, and suicide events with injury. Differences between the pre and post data sets were statistically significant[1] regarding the increases in GRS restraint rates, the percentage of youth involved in a restraint, the total days care, and suicide events without injury.

Taberg made substantial progress with the implementation of CPM and the New York Model until March, 2014. At the beginning of 2014, Taberg had established its administrative team, which improved stability and continuity. Demonstrable progress was evident, and the QAI Report noted pre-crisis skills by staff to resolve emotional upset and reduce uses of force early in 2014. The institutional climate had improved, and the atmosphere in the living units and school annex was much calmer. In other words, Taberg had developed an organizational capacity under the current Facility Director capable of creating a safe environmental context where treatment could be effective.

A. Threats to Protection from Harm

Disruptions to the structure, order, organization, and perceptions of safety had serious implications for Protection from Harm: 1) the purposeful use of sexual abuse allegations; 2) GRS changes from "green" to "yellow" (March) and "yellow" to "red" (April through December); and 3) the even more profoundly negative impact on the mental health status of some of the girls. Presently, the reductions in new allegations—and the innovative strategies to reduce possible harm to other residents, i.e., the "Jessica Project" — are more reflective the current state of anticipating and preventing re-traumatization.

1. Youth Perspectives

Beginning with the August 2012 monitoring visit, the PH Monitor has administered to a stratified non-random sample of Taberg youth selected by the PH Monitor from youth

named on the ARTS list a survey regarding the facility using questions from the Performance-Based Standards (PbS) Project's Youth Climate Survey. Table 1 shows the changes in youth responses to the PH Monitor over the past four monitoring visits. The numbers suggest a return to pre-crisis levels in some of the areas.

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

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

These youth further told the PH Monitor that high numbers of physical restraints are a way to manipulate the system. In the absence of enough staff to conduct group and individual activities, staff are unable to respond when bullying occurs; and restraints and personal safety watches are ways to get room time. Multiple youth indicated that they do not believe they are being helped at Taberg, two indicated that they thought they were getting worse. One said, "There are not enough clinicians, and that's not my fault!" More staff was a common response to the question, "What needs to happen to make this a better place?"

Some caution is needed in the interpretation of these survey data, given the high number of cases where Taberg youth made allegations against of staff sexual misconduct that were subsequently determined, after Justice Center investigations, to be unfounded. This caveat would be more compelling if more youth who made the false allegations against staff had persisted in maintaining that the allegations were true instead of being so quick to tell the PH Monitor (and presumably the Justice Center investigators) that the allegations

were, indeed, false and were used by the youth to manipulate the operations of the unit. These youth believed they would benefit from making such statements.

The comments about the levels system and the DAS were consistent. Youth complained of favoritism and the failure of staff to follow the procedures. Most youth complained that it takes too long to move through the system.

The majority of girls had not made sexual abuse allegations against staff and, during their interviews, each said that the allegations were false and unfounded. They indicated that the allegations were used for several specific purposes: getting attention, getting out of the building (going to the hospital for an examination), getting special attention at the hospital (oftentimes ginger ale and snacks), retribution to certain staff members for holding youth accountable, and the rush associated with the power to get certain staff members off the unit and the youth-held belief that these staff members would be fired. Youth continued to say that staff care too much about the youth to be involved in any sexually inappropriate behaviors.

When asked to explain the reason why false sexual abuse allegations were made against staff, the same mix of issues emerged:

a. A highly sexually charged peer dynamic remains.

b. Taberg girls continue to be angry with certain staff members. This does not imply that staff are performing their jobs inappropriately; but the youth gave credible responses when discussing their anger.

c. Boredom continues to be a common explanation for the deliberate use of staff sexual abuse allegations and uses of force.

d. Unresolved treatment and safety issues were also mentioned as explanations. To the degree that unresolved mental health issues contributed to the destabilizing of the environment, other youth tended not to feel safe.

Little change in the list was noted in December 2014; however, some signs of improvements in each area were evident.

2. Diminished Staff Effectiveness

Previous staff interviews confirmed the stress under which they approach each new shift. Three themes emerged as serious problems from the perspective of staff. First, consistency had eroded to the point that basic behavior management strategies were no longer effective. Staff pointed to the Daily Achievement System (DAS) as ineffective because of the lack of consistency in staffing assignments that results in the inability to know the youth well enough to reinforce youth who had been doing well. Second, some staff fear that the youth are now in charge of the facility or, stated differently, that the youth have been emboldened to behave inappropriately because of what they believed to be the lack of timely consequences for misbehaviors, i. e., the admittedly false sexual abuse allegations. Third, staff expressed frustration and some fear because of their perception of a staff shortage aggravated by the stress of too much overtime.

The lead and veteran staff described each shift as a "nightmare." There are simply too few people to adequately staff a shift and supervise the youth. A staffing calculation

disparity exists between the approach used by OCFS as reflected in the QAI Report, which are substantially lower than other coverage and assignment computational strategies. On the surface, these numbers would predict a staffing shortage without having to set foot in the facility or talk to staff. These numbers are aggravated by the volume of staff who are on leave or restricted duty (13 staff on restricted contact, three staff on administrative leave or workers comp, and two new staff who have not completed CPM training). As a result, YDA overnight staff indicated that they often average 3 to 4 shifts mandated for overtime per week. This means that staff cannot plan ahead for any personal or family activities, making the job the controlling factor in their lives. Keeping their Taberg YDA job is important for these individuals who typically are working three 16-hour shifts and two 8-hour shifts, are exhausted as a result, likely unable to use their best techniques, but live in an area where there are few other employment alternatives.

Staff complaints about low morale were more prevalent than in previous monitoring visits. While there was increasing confidence in the role of the Justice Center investigators, staff had considerable difficulty understanding the difference between the interviewing strategies of OCFS investigators and those conducting a law enforcement style investigation. Fortunately, the tentative agreement between OCFS and the Justice Center may lead to a substantial reduction in the amount of time for conducting a staff sexual assault investigation, the determination of a finding, and the filing of the report.

Outwardly, YDA staff expressed confidence in themselves, their coworkers, and the system because they had done nothing wrong, so all these allegations would ultimately be unsubstantiated. Inwardly, however, they seemed more than a little unsettled by what they perceived to be a lack of support, even a lack of commitment, by Home Office. For the first time since the beginning of the monitoring, staff openly questioned the intentions of Home Office regarding Taberg. Their perception was that the lack of support has to do with a larger agenda that does not include the continued operation of Taberg. Multiple staff expressed their belief that it was the intention of the State to close Taberg.

B. Use of Restraints

The Taberg GRS protocols triggered this “Red Flag” Restraint Review.

The DOJ-generated “Red Flag” Restraint Review became part of the use of force monitoring strategy as a derivative of the agreement between DOJ and the State. The “Red Flag” Restraint Review requires a more granular and inductive approach to compliance determinations, which would have been reasonably well understood and anticipated by the State when it raised the “number of restraint” objections to DOJ. The “Red Flag” Restraint Monitoring starts with specific observations to detect patterns and regularities that would support broader generalizations and general conclusions related to compliance. The inductive approach involves an accumulation of individual level data elements where the PH Monitor begins with a specific restraint incident and reviews the Restraint Packet (the documentation and the video) using each component in each sentence of the Settlement Agreement paragraph as points of analysis along with the restraint evaluation factors articulated in the QAI Report. Once a “Red Flag” Restraint Review is triggered, acquiring a sufficient amount of individual data to reliably establish patterns and regularities in the absence of aggregate data analyses means that a greater number of restraint incidents will

need to be included in the Monitoring. In other words, to move confidently to a general conclusion under this approach requires a larger sampling of restraint events over a designated time, usually the period between Monitoring visits.

The "Red Flag" Restraint Review of Taberg restraint activities included a stratified, non-random sample of Restraint Packets based on the complexity of the restraint (for example, notation of multiple restraint techniques and multiple staff members involved), the length of the restraint, preliminary indications of injuries to youth or staff or referrals of staff for investigation, and the date of the incident with dates closer to the Monitoring visit having a higher priority. The sample of nine (9) Restraint Packets contained multiple problems, which provided an opportunity to evaluate the systemic responses to the correction and remediation of difficult circumstances.

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

The review of the Central Services Unit (CSU) Restraint Log regarding use of force raw data between August 1 and December 9, 2014, identified four (4) unauthorized restraints (Paragraph 41), 12 uses of handcuffs during a restraint (Paragraph 41a), and 19 indications of injury to youth during the restrain (Paragraphs 42f and 44c). If current practices and the facility population remain the same, these data categories project annualized totals of 11 unauthorized uses of force, 33 uses of handcuffs during a physical restraint, 53 injuries to youth during the restraint. The same data project 855 physical restraints annually. OCFS is quick to point out that some use of force is necessary with this population of youth, and there may be some truth in this position; however, justifying annualized uses of force at this level seems to imply that the intervention is ineffective.

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

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

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

The PH Monitor reviewed nine (9) Restraint Packets of youth who were housed at Taberg between August 19 and the October 20, 2014. The justifications listed in the documentation for initiating the use of force in all nine (9) Restraint Packets was for the "safety of any person" (Paragraph 41i). Of these, five packets were inconclusive, leaving only four restraint packets for consideration. Two of these restraints (616304 and 618800) were not justified on a safety rationale because the youth were seated at the time the restraint was initiated. Youth who are not complying with staff directives by sitting down are usually not threatening the safety of themselves or others to a degree that use of force is justified. So, half (50%) or slightly less than a preponderance met the justification requirement.

Taberg staff members are sensitive to restraint rates, especially those situations where staff decisions may inadvertently escalate a youth's behavior versus situations where different decisions would likely have continued de-escalation and, thereby, avoided a restraint. Taberg administration is sensitive to the needs of youth and staff in conflict situations, and the emphasis on coaching and DI has also improved. Administration attempts to use coaching and DI in situations where staff did not handle the restraint appropriately. The current situation has altered these factors due to the uncertainty about what to do, the second-guessing of how to handle unique circumstances, the fear of a false allegation, and the presence of inexperienced and/or exhausted staff.

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; but the evidence of a corresponding practice in the aftermath of the sexual abuse allegations cannot be verified. The absence of restraint video combines with the increased uses of mechanical restraints to challenge the existence of a practice that complies with the paragraph.

Of the nine (9) previously mentioned Restraint Packets, the average amount of time "necessary to stabilize the situation" through the application of force was 44 minutes. Additionally, handcuffs were used to supplement staff uses of force during six (67%) of these restraints with the application of mechanical restraints lasting an average of a little more than 18 minutes. While these activities may be consistent with OCFS policy and procedure, they reflect a practice that should prompt reconsideration by OCFS of "only the minimum amount of physical control and time in restraints necessary."

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 PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report to support this finding. While policy and procedures exist, the training on the policies and procedures has occurred, and staff and resident interviews were consistent with the policy and procedures, an insufficient coherence exists between the IIP recommendations and YDA assessments of their effectiveness. As a result, some Restraint Packets indicate that IIP recommendations were not used.

Of the nine (9) previously mentioned Restraint Packets, eight (89%) had documentation that staff used the de-escalation strategies from the youths IIP. None of these uses were evaluated in the documentation as effective. It is understood that this sample of the Restraint Packets represents some of the most challenging situations for staff regarding use of force; but they also underscore the disconnect between what the collective wisdom of the support team recommends as strategies for helping youth reestablish emotional regulation and the difficulty of effectuating that emotional calming during a crisis situation even though the youth is part of the team coming up with these strategies.

YDA staff members appeared to pay greater attention to the physical limitations that modify or restrict CPM than to a specific youth's psychological risks from restraint. An unreasonable expectation would be an absolute adherence to the IIP, but expecting more parallels between the IIP and staff behaviors is reasonable; and examples existed during this monitoring visit where staff were effective at the prescribed de-escalations.

During the monitoring visit, PH Monitor observed two examples of effective de-escalation, both by YDA Spina. In the first instance, a youth was out-of-control and in a four-person seated restraint. Upon arriving, YDA Spina worked diligently to get the youth's attention without escalating her behavior, using a slow and calm voice, and negotiated with her a release from the restraint. In the second instance, a different youth was roaming the

Annex hallway, cursing, and threatening staff. YDA Spina again used a calming voice and behaviors, pleaded with the youth to "stop and think," invited her to talk to him, and got her to move out of the hallway and away from other youth. These are the types of staff behaviors that need to be included in the development of the youth's IIP and safety plan. They were also characteristic of staff interactions during the monitoring visits last year and affirm the existence of a core group of YDA staff who can create and sustain a peaceful living environment if provided the necessary resources to do so.

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

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

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

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

COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Use of Force Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Taberg QAI Report support this finding. The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. There has been an elimination of facedown or prone restraints. Isolated instances continue to occur as a result of unusual circumstances or concerns about individual staff members, but these are mostly technical failures or accidental circumstances as in Restraint Packet 618800 and do not represent systematic problems.

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

SUBSTANTIAL COMPLIANCE

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

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

SUBSTANTIAL COMPLIANCE

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

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.

SUBSTANTIAL COMPLIANCE

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

The Monitors have not received an opinion from the OCFS Medical Director, regarding possible health and sanitation modifications to the YDA staff training based on the circumstances in the 20 special request incidents where Taberg youth introduced bodily fluids and excrements into the physical restraint process. The initial request was made in the previous Taberg Report.

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.

SUBSTANTIAL COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: The logic of the New York Model (as is common with most behavioral treatment systems for juvenile correctional facilities) is that the application of its principles and techniques by youth and staff should increase emotional regulation in the face of problems and crises and, thereby, mitigate the accompanying practices governing uses of force. This does not imply that the New York Model will eliminate the need for an occasional use of force or physical restraint, and the Monitors have never suggested that it should. Instead, if this "accompanying practice" were an effective use of New York Model principles, the "amount of force necessary" would be lower.

If the use of force was not justified according to the criteria in Paragraph 41, then it follows that the use of force was also is not the least amount necessary for the safety of staff and youth. Of the nine (9) previously mentioned Restraint Packets, only two packets

had sufficient video evidence to support the safety justification, and five packets were inconclusive. In other words, half (50%) or slightly less than a preponderance met the justification requirement.

Extremely stressful work conditions like those that exist at Taberg strain the ability of even the best staff to maintain the appropriate level of professionalism and emotional neutrality in the face of danger situations with extremely challenging youth. When staff are demoralized by what appears to be the endless needs of youth and too few staff to address them, youth begin to mirror that frustration, despair, and anger. While these are the circumstances where isolated instances of excessive force occur as identified in the QAI Report and the "Red Flag" Restraint Review, it is at these times when the problems occur.

Not only has current practice resulted in an increase in the uses of force, but the data also indicate an increase in the amount of force as measured by the use of handcuffs because of the intensity and duration of a youth's struggles during the restraint. See the comments for Paragraph 41a. By policy, mechanical restraints are applied when the youth's behavior is out-of-control, and they are to be removed when the youth's behavior is or returns to an acceptable level of safety. In addition to the increased uses of physical restraints and mechanical restraints, the amount of time a youth is "out-of-control" as measured by the length of time in handcuffs remain at a precarious level. In response to the Monitors concern about mechanical restraints, Home Office has proactively begun to address the duration of the use of handcuffs through a December 5, 2014 memorandum to all facilities implementing safeguards requiring the approval of the Deputy Commissioner of the Division of Juvenile Justice and Opportunities for Youth (DJJOY) to extend the use of handcuffs after a certain time threshold.

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: The GRS provides important information for compliance determinations for this paragraph. The Therapeutic Intervention Committee (TIC), in conjunction with the

administrative review of restraint packets, is the "review by senior management." The TIC has two components, the Home Office TIC and the facility TIC. At the Home Office TIC, the Settlement Coordinator assembles a team of OCFS senior leadership staff from the relevant departmental disciplines to address, evaluate, and modify the response plan. The facility TIC has mandatory attendees that include the Facility Director or designee, Clinical, Assistant Director, AOD, YDA, YC, Medical, Kitchen, Maintenance, Recreation, Spiritual (if on staff), Education, and youth (for last agenda items only). Additionally, these TICs are the mechanism tied to the OCFS restraint metrics by which GRS "red zone" status moves to "yellow" or "green" status. Table 2 charts the 2014 performance of the TICs for Taberg. The results are less than acceptable. At no time is the GRS "red zone" status moved to "yellow" in fewer than 90 days; Taberg spent nine months in 2014 in GRS "red zone" status; and five months of these GRS "red zone" determinations were at a level twice the GRS "red zone" threshold, the most critical being the most recent.

Table 2. 2014 Graduated Response System Data

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	2014
Care days per month	606	627	694	592	665	625	631	738	720	707	662	644	7911
Total Number of Unique Standing/Escort:	5	9	32	23	41	21	15	36	34	28	31	40	315
Standing/Escort Rate Per 100 Days	0.83	1.44	4.61	3.89	6.17	3.36	2.38	4.88	4.72	3.96	4.68	6.21	3.98
Total Number of Unique Ground/Restraint:	4	16	38	21	31	25	16	40	29	40	43	64	367
Unique Ground/Restraint Rate Per 100 Days	0.66	2.55	5.48	3.55	4.66	4.00	2.54	5.42	4.03	5.66	6.50	9.94	4.64
Technique Not Sanctioned Rate Per 100 Days	0.00	0.16	0.00	0.17	0.00	0.00	0.00	0.00	0.00	0.42	0.15	0.47	0.11
Total Unique Restraints	9	26	70	45	72	46	31	76	63	71	75	107	691
GRS Zone	1.49	3.99	10.09	7.43	10.83	7.36	4.91	10.30	8.75	9.62	11.18	16.15	8.62

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

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

PARTIAL COMPLIANCE

COMMENT: The PH Monitor's review of multiple Restraint Packets, including the Video Review Forms (VRF), combines with administrative interviews and the conclusions from the Taberg QAI Report to support this finding. The policy and procedures exist, and there is a practice in place. An SG-18 or above facility administrator completes a review

and logs the information and recommendation on the OCFS 2091 form, which is reviewed by the Facility Director.

Throughout the monitoring process, this paragraph has become more important because of the "review" and "evaluate" functions contained in this weekly practice. The Facility Administrator Review becomes a critical part of the feedback needed to enhance the effectiveness of CPM within the New York Model. With the advent of QAI, the Facility Administrator Review provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Taberg has yet to move the Facility Administrator Review to the YC level as successfully implemented with the Intact Teams at Finger Lakes. Until recently, Taberg's Assistant Facility Director for Programs did all of the Facility Administrator Reviews. Due to the increased administrative responsibilities generated by the sexual abuse allegations and the increased numbers of Restraint Packets in need of review, a few Video Review Forms (VRF) appeared rushed and, in some instances, incomplete. Now, without an Assistant Facility Director for Programs, the Facility Director assumes the responsibilities of the Facility Administrator Reviews, moving this critical and educational process farther away from the direct care staff levels.

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

Disruptions to work schedules have negative impacts on personal lives, job performance, and staff morale. Therefore, adding training or coaching requirements to a harried YDA staff member in the midst of this level of disruption has rarely been interpreted as a constructive or helpful gesture. Yet, critical problem-solving and mandatory analyses of situations remain essential parts of effective facilities. In addition to the drop in a) recommendations for DI in this "Red Flag" Restraint Review and b) comments on the administrative review that signify important issues for consideration, modification, new training or policy revisions disappeared entirely in the June 2014 review and were scarcely present in this set of Restraint Packets.

Of the nine (9) Restraint Packets in this "Red Flag" Restraint Review, five (56%) contained evidence of inappropriate applications of the CPM techniques. At the very least, there should been documentation of at least five requests for DI in the Restraint Packets. However, there were only four Restraint Packets that contained requests for DI. Based on the PH Monitor's review, eight (89%) of the Restraint Packets contained sufficient documentation to warrant requests for DI. The need exists to improve the documentation of inappropriate applications of CPM techniques and to implement corrective actions through the request for DI. This observation is consistent with the Taberg QAI report that called for administration to increase the use of DI to provide continued and ongoing training in the critical area of proper uses of force. These are appropriate recommendations when adequate staff resources exist, which are not currently the case at Taberg.

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

SUBSTANTIAL COMPLIANCE

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

C. Emergency Response

Until the rash of allegations and their aftermath, the levels of emergency response seemed good, and the policy and procedure regarding response codes appeared appropriate. Now, compliance considerations for Paragraph 43 have changed for Taberg. The unintended consequences of the Taberg sexual abuse allegations exposed institutional responses that proved too formulaic and rigid. Both OCFS and Justice Center have made admirable adaptations to their systems to increase their responsiveness.

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.*

SUBSTANTIAL COMPLIANCE

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

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

COMPLIANCE

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

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

SUBSTANTIAL COMPLIANCE

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

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

SUBSTANTIAL COMPLIANCE

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

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU) and the new Justice Center, officially implemented as of June 30, 2013. The Monitors appreciate the information provided by Home Office on the development and responsibilities of the Justice Center, but questions remain about its relationship to certain Settlement Agreement paragraphs. The Monitors recommended that any implications for monitoring be resolved first by the Parties (Home Office and DOJ). As such, the Parties have agreed to the following:

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

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

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

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

To this end, the State shall:

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

SUBSTANTIAL COMPLIANCE

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

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

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

Second through Fourth Sentences: COMPLIANCE

COMMENT: In those instances of allegations, the Facility Director made the initial determination in conjunction with her supervisor (the Facilities Manager) and with OCFS regional staff supervised by another arm of OCFS that oversees the creation of safety plans. No problems or concerns were noted regarding a prompt determination or an appropriate level of contact.

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

COMPLIANCE

COMMENT: Taberg has sustained its compliance with this paragraph. The clinic remains a Protection from Harm strength. Reviews of Post Restraint Examinations (PRE) were complete and comprehensive, and the number of restraint events noted in the CSU

Restraint Log corresponded to the number of PREs. The procedures for the Post Restraint Examination remain the same.

The QAI Report noted the number of times that youth did not receive the PRE in the prescribed 1 hour after the restraint per policy. The clinic staff indicated that they note the time that a code white is called and look for a PRE approximately an hour later. If there has been no notification to the clinic about the PRE within an hour time limit, a nurse will call the AOD and ask when the PRE can be accomplished. If a delay occurs, the clinic staff indicated that it is because the AOD determines the situation to be unsafe at that time. In these instances, nurses will go to the unit to observe the youth to make sure that there are no acute health issues. The absence of a sufficient number of YDAs to staff the shift is frequently an underlying contributor to the delay.

In one interview, a girl indicated that she had been part of a sex trafficking ring before coming to Taberg. Based on this information, the PH Monitor asked the nurse about routine testing procedures for sexually transmitted infections, HIV/AIDS, and hepatitis C. While reviewing the youth's file, which confirmed that these tests had been completed or had been scheduled, the nurse indicated that the youth had tested positive for THC at arrival at Taberg. When asked why drug testing would occur at Taberg as opposed to reception, the clinical notes indicated that it was because staff believed there had been a marijuana smoking incident with another youth during transportation to Taberg. The information was reported to the Settlement Agreement Coordinator.

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

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

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

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

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

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

44. f. Provide adequate training to staff in all areas necessary for the safe and effective performance of job duties, including training in: child abuse reporting; the safe and

appropriate use of force and physical restraint; the use of force continuum; and crisis intervention and de-escalation techniques. Routinely provide refresher training consistent with generally accepted professional standards.

SUBSTANTIAL COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: The level of disruption and chaos has had an adverse effect on staff supervision due to the small size of the facility in the absence of staffing inadequacy. Uses of DI, coaching, and supervisory follow-up must return to acceptable levels similar to those experienced by staff at the end of last year in order for supervision of staff to be consistent with generally accepted professional practices. Of the nine (9) Restraint Packets in this "Red Flag" Restraint Review, five (Packets 616101, 616804, 618799, 618800, and 621199) contained video evidence of staff behavior that warranted DI or coaching, but the packets contained inadequate or insufficient documentation to initiate a corrective action. In one instance, the QAI review prompted the corrective action. The difficulty in making recommendations about compliance thresholds or specifying necessary improvements is greatly compounded by the lack of staffing adequacy.

Beyond YDA and YC/AOD supervision, the September 2014 change in Taberg's Facility Manager resulted a discernible change in the content and tone of the Facility Manager Reports, particularly the elimination of references to previously cited problems getting the Facility Director adequate resources consistent with the concerns indicated in the monitoring reports.

44. h. The State shall utilize reasonable measures to determine applicants' fitness to work in a juvenile justice facility prior to hiring employees for positions at the Facilities including but not limited to state criminal background checks. The State shall update state criminal background checks and SCR clearances for all staff who come into contact with youth every two years.

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

III. MENTAL HEALTH MONITORING

This site visit at Taberg showed staff working hard to implement the New York Model. Addressing a wide range of developmental and mental health needs is a continuing challenge in a facility that is the only limited secure program for girls and has the only mental health unit for girls in the state. Most of the girls on both units have challenging behavior driven by trauma and many do not have a re-entry placement likely to provide permanency and adequate support to continue the progress they make at Taberg. It is

almost impossible to have sufficient trained staff to provide the 1:1 attention and support for self-calming necessary in a unit full of 12 girls who constantly trigger each other.

It is good news that Taberg expects to have its full clinical team for the first time, with four clinicians, one substance abuse clinician and the Assistant Director for Treatment. Although the number of high needs girls remains a challenge, it will be possible to achieve the required minimum once weekly individual therapy.

The clinicians have supported staff in providing more 1:1 attention for girls before they reach crises in order to help girls learn to regulate their emotions. The use of "Code Grey" to indicate that a girl is escalating, and the clinicians' responsiveness by arriving immediately and supporting the girl to calm herself has also been effective. Both are demanding on staff and cannot be maintained without fewer residents or more YDAs, YCs and clinicians. That six of the girls at Taberg in December, 2014 had been there during stressful times in the spring and some were involved in false allegations (half the residents had been at Taberg for five months or more) may have resulted in slower acceptance of new staff and a tendency to rely on negative attention. Staff are working together to help girls out of the perception that "it takes negative behavior to get attention" by responding to individual needs immediately before they escalate.

The two units at Taberg are not operating different programs and both units have continued to have residents with complex mental health needs. Home Office is considering making Taberg a single mental health-focused program for girls in order to provide consistent services using an intact team approach since "all of the youth admitted to Taberg can benefit from services typically provided on a Mental Health Unit."

The shortage of YCs and the lack of an Assistant Director for Program remain serious problems at Taberg. Due to Civil Service test scores, Taberg had two talented individuals who were acting as YCs have to return to their roles as YDAs. New YCs had not yet arrived, and there was a shortage of YCs both for case management responsibilities and for AOD shifts. During the site visit, YDAs were exhausted. New YDAs are being trained and will provide relief, but it is a continuing strain to have both units full of high needs residents.

The MH Monitor is focusing on staff demonstration of consistent New York Model practices to determine compliance. The biggest obstacles to New York Model implementation at Taberg remain the large number of extraordinarily high-needs girls and too few staff for the intensive support they require.

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

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

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

COMPLIANCE

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

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

The QAI review of the New York Model implementation at Taberg examined residents' records for integrated assessments, psychiatric evaluations, support plans, diagnoses, psychiatric contact notes, medication, family outreach, suicide response, substance abuse services and release planning, staff and residents were interviewed, and support teams, Mental Health Rounds, and groups were observed in the QAI review.

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

COMPLIANCE

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

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

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

COMPLIANCE

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

Through support teams and Mental Health Rounds, Taberg staff are complying with 46c on an individual basis. The Taberg Integrated Assessment, IIP, Support Plan, and contact notes by the psychiatrists, clinicians, YCs and CMSO were all accessible on JJIS and comply with 46c. JJIS is designed to capture how a strengths-based, trauma-responsive approach is being implemented with each resident and tracks the diverse interventions of the New York Model. JJIS makes it possible to document practice according to the procedures that comply with several mental health paragraphs in the Settlement Agreement and allows for the regular assessment of the effectiveness of interventions required by 46c.

The PH Monitor and MH Monitor observed the Taberg TIC convened by the Director and attended by 30 staff (mostly YDAs from two shifts, plus YCs, clinicians, education, and nurses). Staff were thanked for their hard work and their pride in the consistency of the Taberg program. "With 35 new staff this year, it's a lot to get staff trained and involved. Everyone's tired, everyone's overextended, holidays are coming up. It's going to feel better soon—overtime will go down." There was no mention of the increase in restraints and

what the intact teams would be supported to do about them. Effective use was made of three videos: in one, three YDAs were commended for their patience while a resident hit and shoved them; in another with a girl on arms length supervision, there was a reminder on how ALS should be handled; in the third, 12 girls were in the classroom with one teacher and three YDAs plus a YDA on ALS and the discussion was about what could have been done differently to anticipate and prevent a girl's attack on a peer. A clinician addressed other staff: "What you do 8-16 hours a day is phenomenal. All the things you do so well with residents." A seasoned YDA thanked clinicians for their active involvement. A new YDA appreciated senior staff for their guidance. A new teacher thanked YDAs. The TIC would have been a good place to talk about the discharge of seven girls in the coming month and its impact on the facility, but it was not mentioned. Many girls in the facility appeared to be grieving. The departure of almost a third of the residents, especially at the holidays, is an opportunity to help everyone with loss, imagining moving on to new relationships, recognizing how much they have grown and challenging the girls who remain to be the next ones to make so much progress.

Meeting notes from the Taberg TIC in previous months showed discussions about progress made and improvements necessary in the program. In August, 2014, the TIC meeting was a mandatory staff meeting in which videotapes were reviewed. At the September, 2014 TIC meeting, the decrease in restraints and a mid-month spike in restraints were noted. There was a discussion of the proper technique for arms' length one-on-one with a resident. Guidelines for the Comfort Room as a place for residents to "re-regulate their affect, use skills, accept coaching, and calm down" were discussed. In October, 2014, the TIC meeting noted restraints were still on the decline. A faculty member from Sanctuary spent the day at Taberg and presented at the TIC, offering to provide additional problem solving in the future. In November, 2014, at the TIC meeting it was announced that Sanctuary staff and the Buffalo CMSO were planning a lunch for Taberg staff. Restraints continued to decline, with 23 of the 33 restraints so far during the month being two residents. Red Flag meetings on four residents were discussed.

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

COMPLIANCE

The Facility Admission and Orientation policy (PPM 3402.00 Limited Secure and Non-Secure Facilities Admission and Orientation and PPM 3402.01 Secure Facilities Admission and Orientation with the Admission Checklist, Orientation Checklist and Facility Classification forms) and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") are consistent with the New York Model and comply with 46d.

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

On Site Observations Regarding Paragraph 46a-d (12/14)

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

with Paragraph 46, but OCFS is choosing to comply with Paragraph 46 with the New York Model.

The New York Model has been implemented at Taberg. Integrated assessments and support plans continue to need improvement. Support teams are excellent, although they seldom include YDAs. The Daily Achievement System (DAS) and phase system are in place. Taberg staff continue to work diligently to achieve trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet residents' complex needs. All the girls at Taberg have long histories of trauma and troubled behavior, and staff dedication to teaching residents emotional regulation was apparent.

The MH Monitor observed the new Mental Health Rounds in which all 23 girls in the facility were discussed, with the clinician presenting a current report about each. The purpose of the meeting appeared to be to update the psychiatrist, clinicians and YCs. There was little discussion of diagnosis or symptoms being treated with psychiatric medicines. One resident was described as a success story, having made "a complete change on the unit, in school and in counseling with her mother." Two residents, both prescribed anti-depressants, who were preparing to leave were described as grieving the loss of their mothers. A resident prescribed three psychiatric medications had gone two weeks without assaulting staff. Another resident was no longer taking medication and had gone 11 days without codes or making allegations. Several residents were described as having high anxiety about leaving. Three residents were avoiding "deep discussions." The psychiatrist talked about a trial of an antipsychotic medication for one girl and an antidepressant for another. Mental Health Rounds discussion focused on individual girls. The meeting could also be an opportunity to encourage participants to guide trauma-responsive interventions by all staff. The shortage of staff meant that few YCs attended Mental Health Rounds, and since only one new YDA participated, clinicians must convey the observations to the intact teams.

The MH Monitor observed a strong intact team meeting with 12 YDAs, 4 clinicians, and a YC reviewing all the girls on the unit, starting with each IIP and the clinicians suggesting interventions to reduce escalation by each girl. One clinician provided especially strong coaching, encouraging staff to be outspoken and there was open exchange among staff. Valuable suggestions were given for specifically how to use IIPs for several residents who all staff find challenging. Building strong intact teams at Taberg will be helped by a psychologist, a social worker and a YC being assigned to each unit.

The MH Monitor observed a DBT group led by a clinician with minimal YDA involvement. The clinician involved several of the residents in the presentation and was able to make the group meaningful even for those who did not speak up. Supporting staff to use DBT skills on the unit is a priority and would also make group discussion more rewarding.

Because of a shortage of clinicians and then of YCs, Taberg YDAs have been leading many groups, for which they should be commended. The MH Monitor observed a Sanctuary group on a unit where residents had been having behavior difficulties for days. Involving girls—two of whom had been there less than three weeks and two who were

among the longest stay residents at Taberg—in a review of examples of different kinds of safety was a challenge, but many of them contributed.

The coaching team is pleased with progress toward Taberg being fully staffed with clinicians and YCs. Trusting relationships are being built and staff more frequently ask for guidance from clinicians. The coaching team said they try to show gratitude to YDAs who work long hours and are tired. They hope to involve more YDAs in support team meetings. They are providing support for de-escalation techniques and using IIPs for individualized help for girls—this is easier as staff get to know each resident. Teaching everyone how to get ahead of residents' feelings and behaviors instead of being reactive is one of their coaching goals. The Taberg trainer involved a clinician to do a mental health training using Taberg girls as examples. Their next collaborative staff training will be on understanding trauma. The coaching team is working on how staff can reverse the perception "You have to do negative behavior to get attention." They had increased their use of ALS and watches to provide extra support to girls having difficulty. They noted that "We have to make sure we are responding to positive behavior. We have to constantly question ourselves, 'What's our program reinforcing?'" The coaching team saw the importance of starting to prepare staff and remaining residents for seven residents leaving Taberg soon.

A clinician led the development of an innovative intensive plan to meet the needs of a resident who had been at Taberg 9/13-8/14, was described as the "eye of storm" during the spring, had gone to a RTC and returned 9/27/14. With two staff with her, they helped her identify her underlying needs. For example, she gets very frustrated and to be able to prevent her escalation, staff have to "take a step back." While this intensive support was a tremendous strain in staff hours, for 29 days the resident was able to get her needs met positively and she transitioned to 1:1.

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

During 10/15/14-11/15/14, one clinician saw four residents in individual therapy, one twice and three once (three were prescribed medication and should have been seen weekly). During 10/15/14-11/15/14, a second clinician saw seven residents in individual therapy, four twice and three once (all were prescribed medication). During 10/15/14-11/15/14, the third clinician saw four residents in individual therapy, one twice, one four times, one five times, and one six times and three once (all were prescribed medication).

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Taberg records; support plans indicated the IIP has been reviewed. A Taberg psychologist is preparing exemplary IIPs that are detailed and instructive for all staff. For example, one 17-year old resident who feels helpless was described as having an extreme reaction to particular triggers including "People in her space. When people slam doors. Loud noises. Difficult phone calls. Not being respected. Being bossed around. Name-calling." She was also described as being easily overwhelmed with peers. The psychologist's advice was "Allow her to vent. She doesn't usually express herself verbally, but when removed from peers with 1-1 time, she has talked about her feelings and thoughts." A 14-year old resident's IIP indicated "she shows symptoms of severe trauma in her relationships with peers and staff. She can be easily triggered to react aggressively but she responds positively to maintaining a relationship with staff. She has made great strides. She continues to need support to attend to her impulsive reactions to negative thoughts and experiences in addition to her history of trauma. Ask her what need is not being met. Ask her how she is feeling and help her trace back what her triggers were in this situation."

The MH Monitor observed a pre-shift briefing led by the AOD involving 22 Taberg staff. It provided an effective update on the climate of the two units, particularly the status of girls on 1:1 and several girls in crisis. This briefing is an opportunity for coaching by reminding staff how to model and support the girls in using skills to tolerate distress and regulate their emotions.

The MH Monitor reviewed DAS sheets of a resident whose support team was observed, demonstrating some improvement in her behavior.

The QAI Review (11/14) found that Taberg was rebuilding its clinical team with the addition of a third OCFS clinician in August and the Assistant Director for Treatment in September: "This restructuring and sustained stability of the clinical team will be essential for future success. QAI noticed a significant improvement in the quality and quantity of documented clinical contacts with youth, as well as a marked improvement in youth engagement."

The QAI Review (11/14) at Taberg reported that in an observation of Mental Health Rounds in which all 24 youth were discussed for each youth, the YC, clinician, teacher, and psychiatrist provided updates. "The amount of detail and trauma-related concerns shared was significant and informative. When the team spoke about the youth they were genuine and sensitive to the youth's struggles." QAI required plans to have more YDA participation in Mental Health Rounds and strategies to support staff in working with residents with significant loss, anxiety, sexualized behaviors, and trauma-related concerns.

The QAI Review (11/14) at Taberg found in four of the five records reviewed, there was a lack of evidence to demonstrate that individual mental health sessions were provided at the minimum required frequency (those prescribed psychiatric medications are required to have an individual session with the clinician weekly and others an individual session minimally every 30 days). In two of the records, efforts to engage youth who had refused treatment services were not apparent. The clinician who was interviewed reported that a typical day consists of six to seven hours of contact with the youth combined with Support Team Meetings, responding to codes, having staff meetings, making

referrals, contacting families and CST workers. Completing required JJIS documentation was not possible given the multiple and competing priorities placed on clinical staff. QAI required an action plan for improving the frequency and documentation of individual mental health sessions provided to the youth at Taberg.

The QAI Review (11/14) at Taberg required an action plan to improve the timely completion of Integrated Assessments with all components thoroughly and accurately provided.

The QAI Review (11/14) required an action plan to improve development/review of IIPs within 72 hours of a youth's admission to Taberg.

The QAI Review (11/14) at Taberg required a plan for all staff to complete the DAS in its entirety, including achievement level, total points earned, and signatures from both staff and youth.

FUTURE MONITORING

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

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

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

To achieve sustained compliance with paragraph 46 at Taberg will require every resident being seen in individual therapy at least once monthly and every resident prescribed psychiatric medicine being seen in individual therapy weekly. Coaching staff in the integration of DBT and Sanctuary skills on the unit should occur both in individual discussions and by the inclusion of YDAs in Mental Health Rounds and support teams.

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

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

COMPLIANCE

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

The revised PPM 3247.60 "Suicide Risk Reduction and Response in OCFS Facilities" (9/15/14) complies with the requirements of 47a.

Staff at Taberg were observed complying with 47a.

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

COMPLIANCE

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

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

COMPLIANCE

The revised PPM 3247.60 "Suicide Risk Reduction and Response in OCFS Facilities" (9/15/14) complies with the requirements of 47c: "From the point of entry into the DJJOY system, throughout all areas of youth programming and extending to the transition back to the community, staff must be continually aware of suicide risk factors and the possibility of adolescent suicide or serious self-harm. Further, when evidence or information arises about the possible suicidal ideation, intent, or behavior of a particular youth, OCFS will respond effectively to maintain the physical safety and emotional well-being of the youth. A youth shall remain on enhanced supervision status until a mental health clinician authorizes modification of the enhanced supervision or removing a youth from special supervision status based on a clinical assessment. Youth on enhanced supervision status will be seen by a mental health clinician to reassess the need for enhanced supervision as frequently as may be indicated by changes in the youth's presentation, whenever possible every 24 hours."

On Site Observations Regarding Paragraph 47a-c (12/14)

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

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

Taberg had 54 suicide watches between 7/1/14-11/30/14, with an average of 11/month (the same monthly rate as 1/1/14-6/30/14). In 10/1-10/31/14, 13 residents had watches: 7 SWs (7 girls, 5 for 1 day, 1 for 4 days, and 1 for 10 days); 9 1:1s (7 girls, 2 for 1 day, 2 for 2 days, 2 for 3 days, 1 for 7 days, 1 for 8 days and 1 for 9 days); 2 PSWs (2

girls, 1 for 1 day and 1 for 8 days); and beginning 10/28, a special program for a resident. In 11/1-11/30/14, 15 residents had watches: 15 SWs (11 girls, 7 for 1 day, 2 for 2 days, 1 for 3 days, 3 for 5 days, and 2 for 6 days); 6 1:1s (6 girls, 3 for 2 days, 1 for 3 days, 1 for 4 days, and 1 special program); 2 ALS (girls, 1 for 1 day and 1 for 2 days); and 3 PSWs (2 girls, 1 for 1 day, 1 for 2 days, and 1 for 6 days). More than half the residents at some point in the month being on personal safety watch, 1:1 or ALS, or Suicide Watch is a high rate. Completing mental health assessments for suicide every week, and then re-evaluating each resident, is a major time commitment for clinical staff.

Suicide Watch documentation by the clinicians in the Taberg records was thorough as exemplified by a 17-year old resident who arrived at Reception a month before the site visit, and at Taberg 11 days later on an alert after a suicide watch. She was charged with assault at a residential program. Her reception diagnosis was Conduct Disorder, Bipolar Disorder, Polysubstance Dependence, Rule Out PTSD; in the past she had been diagnosed with Reactive Attachment Disorder. She had been in several foster homes, a group home and residential settings, as well as being hospitalized for self-harming behaviors. Her [redacted] committed suicide when she was [redacted] and her mother, from whom she was removed [redacted] was depressed and abusive. She started drinking alcohol at age 9 and also used other substances to numb her feelings. Scoring high risk on the ISO when she arrived at Taberg, she was placed in suicide watch. At Taberg she was initially continued on Depakote and Thorazine. She was seen daily by her therapist during her first week in the facility and twice in 10 days by the psychiatrist. In her second week while on SW, she tightly tied her shirt around her neck requiring the cut down tool and immediate medical attention—she was plagued with memories of being raped and she had been triggered by a phone call with her mother. On her 16th day in the facility, she was hospitalized (11/20-12/6/14) for six days at Pinefield where she was at the time of the site visit. On her return, she and her therapist worked on distress tolerance and addressing her hopelessness from her many placements and relationship with her mother.

FUTURE MONITORING

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

The MH Monitor will review documentation of suicide assessments and rate of Suicide Watch and 1:1 at Taberg.

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

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

COMPLIANCE

The BBHS Facility Clinical Procedures described the Integrated Assessment, which complies with 48a.

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

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

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

COMPLIANCE

The procedure for referring a youth for evaluation to a qualified mental health professional is in place. Memos in 2/12 and 12/12 described the procedure for referral of youth to a committee for a mental health placement (linked to the Behavioral Health Services policy, PPM 3243.33) and complies with 48b.

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

COMPLIANCE

The Integrated Assessment form complies with 48c. The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 48c.

Taberg staff are completing the Integrated Assessment for every resident.

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

continuing progress to achieve universal high quality in the Integrated Assessments is necessary for sustained compliance with Paragraph 48.

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

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

COMPLIANCE

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

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

In 11/14 Supervising Psychiatrist Dr. Faulker visited Taberg. Once Taberg has a full clinical team, the Supervising Psychiatrist meeting with Mental Health Rounds to discuss consensus diagnosis would be beneficial.

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

COMPLIANCE

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

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

On Site Observations Regarding Paragraph 48a-e (12/14)

In December, 2014, the 18 Taberg residents prescribed psychiatric medication had the following diagnoses:

ADHD
Anxiety (3)
Conduct Disorder (2)
Depression (4)

Disruptive Mood Dysregulation Disorder (3)*
Insomnia (8)
Mood Disorder (5)
Panic Disorder
PTSD (4)

* One of these residents was listed as "Mood Dysregulation Disorder"

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

Since the previous site visit, one psychiatrist left and the remaining Taberg psychiatrist is working one 10-hour day/week. During 10/15/14-11/15/14, the psychiatrist was at Taberg one day a week; during the month he saw 19 residents, seven of them once, nine of them twice, and three of them three times. If he were at the facility more hours, he would be able to spend more time with youth and participate in support team and Red Flag meetings. One psychiatrist 10 hours a week appears insufficient given the complex needs of Taberg residents.

The QAI Review (11/14) at Taberg found a decline in performance with 60% of Psychiatric Evaluations scoring within the Meets Standards range. In one record, the reason for the PDE was unclear and the history was not detailed; the youth had a long history of suicidal gestures and the PDE noted no psychiatric history. Another record also lacked history, and there was no evidence that there was a review of the prior records. A third record did not include prior diagnoses of Adjustment Disorder and Rule Out ADHD or past prescription of Seroquel. QAI required a Taberg plan to have the PDEs thoroughly completed in all sections, utilizing prior records.

FUTURE MONITORING

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

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

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

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

49a. Create or modify and implement policies, procedures and practices to require that any psychotropic medication is: prescribed only when it is tied to current, clinically justified diagnoses or clinical symptoms; tailored to each youth's symptoms; prescribed in therapeutic amounts, as dictated by the needs of the youth served; modified based on clinical rationales; documented in the youth's record with the name of each medication; the rational for the prescription of each medication, and the target symptoms intended to be treated by each medication.

COMPLIANCE

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

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

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

The MH Monitor observed the Taberg psychiatrist explaining the rationale for prescribing particular medication to treat a resident's symptoms.

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

from meaningfully participating in treatment, rehabilitation or enrichment and educational services as a result of excessive sedation; and establishing protocols for reviewing such policies and procedures to require that they remain consistent with generally accepted professional standards.

COMPLIANCE

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

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

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

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

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

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

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

COMPLIANCE

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with 49c: "The psychiatrist, psychiatric nurse practitioner and mental health clinician will assess youth for beneficial effects of medicine on the target symptoms. Clinicians meet with youth weekly for scheduled visits. Prescribers meet with youth monthly, and more often when clinically indicated. Each youth prescribed psychiatric medicines shall be assessed by the psychiatrist or psychiatric nurse practitioner every 30 days or more frequently when clinically indicated. The psychiatrist or psychiatric nurse practitioner will conduct a clinical interview including a mental status exam of the youth, review lab results, review clinical assessments for side effects, review and sign medicine refusals, and consider any additional information provided by the clinician and direct care staff who work with the youth. This evaluation shall be documented in the psychiatrist's contact notes in JJIS. The medication treatment will be continued or adjusted as indicated by the findings."

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

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

On Site Observations Regarding Paragraph 49a-c (12/14)

On December 9, 2014, 18 of the 24 girls in residence at Taberg had psychiatric diagnoses and were prescribed psychiatric medication:

ADHD-Trazodone
Anxiety-Effexor
Anxiety-Vistaril
Anxiety-Zoloft
Conduct Disorder-Seroquel
Conduct Disorder-Straterra
Depression-Celexa
Depression-Effexor
Depression-Lexapro
Depression-Zoloft
Disruptive Mood Dysregulation Disorder-Abilify
Disruptive Mood Dysregulation Disorder-Haldol
Disruptive Mood Dysregulation Disorder-Prozac
Insomnia-Benadryl (3)
Insomnia-Trazodone (5)
Mood Disorder-Abilify
Mood Disorder-Depakote
Mood Disorder-Prozac
Mood Disorder-Lamictal
Mood Disorder-Seroquel
Panic Disorder- Lamictal
PTSD- Lamictal
PTSD-Prozac
PTSD-Prazosin and Celexa
PTSD-Zoloft and Trazodone

In December, 2014, six Taberg residents were prescribed three psychiatric medications: a 14-year old was prescribed Lamictal, Effexor and Trazodone, a 15-year old was prescribed Lexapro, Abilify and Trazodone, a 16-year old was prescribed Lamictal, Zoloft and Trazodone, a 17-year old was prescribed Prozac, Haldol and Vistaril, a 15-year old was prescribed Celexa, Prazosin and Benadryl, and a 14-year old was prescribed Celexa, Abilify and Melatonin. The MH Monitor reviewed recent Psychiatrist Contact Notes for three of these residents and found that their current medication regime had been discussed with the Supervising Psychiatrist.

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

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

The QAI Review (11/14) at Taberg found that the Use of Psychiatric Medications scored within the Not Meeting Standards range based on polypharmacy. One resident was

prescribed Lamictal, Zoloft, and Trazodone. Another resident had been admitted to Taberg prescribed Abilify, Lexapro, Trazodone, Trileptal, and Vistaril; Trileptal and Vistaril were discontinued in May, 2014, she remained on Abilify, Lexapro, and Trazodone, and at the time of the QAI record review she was prescribed Effexor, Lamictal and Trazodone. Two residents were prescribed two medications from one class: Zoloft and Trazodone, and Celexa and Trazodone were prescribed concurrently without documentation of approval from the Supervising Psychiatrist.

FUTURE MONITORING

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

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

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

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

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

COMPLIANCE

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

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

COMPLIANCE

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

FUTURE MONITORING

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

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

COMPLIANCE

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

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

COMPLIANCE

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

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

FUTURE MONITORING

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

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

COMPLIANCE

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with the requirements of 52 and contains guidelines for informed consent for psychiatric medicines: "The assent and understanding of the youth shall be sought for psychiatric medicines. The youth needs to understand, in accordance with his or her developmental ability, how the

medicine may impact the way he or she feels, acts, and thinks, as well as the benefits and risks of treatment. To obtain assent, the psychiatrist shall discuss with the youth in person, the name of the medicine, the dose, and the reasons for prescribing, common side effects, and potentially serious side effects, and obtain the youth's verbal assent to comply with the treatment. The youth's verbal assent will be documented in the psychiatrist's evaluation or contact notes."

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

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

The QAI Review (11/14) at Taberg found that the Use of Psychiatric Medications scored within the Not Meeting Standards range based on three out of five records, due to a lack of diligent efforts in obtaining written consents from families.

FUTURE MONITORING

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

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

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

COMPLIANCE

The New York Model implementation training included the integrated assessment and support plan and how to utilize both in support teams.

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

The support team practices at Taberg comply with 53a.

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

COMPLIANCE

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

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

COMPLIANCE

Support team meetings at Taberg comply with 53c.

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

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

PARTIAL COMPLIANCE

Some Taberg Integrated Assessments, clinical evaluations, and Mental Health Rounds describe the effects of trauma on residents' thinking and behavior and are part of planning interventions. Some residents' support plans, a key aspect of the New York Model, do not include trauma. To meet the Settlement Agreement's requirement for "a strategy for developing coping skills [for trauma] by the youth," the effects of trauma on the resident's behavior must be part of staff assistance in the youth's development of goals, and trauma must become a safer topic in the process of residents changing their thinking and behavior. Compliance with 53d means demonstrated improvement in support plans that incorporate the resident's trauma history from the Integrated Assessment and tailor skill-building in response to it. Expert trauma treatment consultation for clinicians and YCs may be warranted, followed by improved understanding in Intact Teams of how DBT skill-building and residents feeling safe are parts of trauma recovery.

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

PARTIAL COMPLIANCE

Mental health staff at Taberg were observed complying with 53e and the support team meetings observed by the MH Monitor complied with 53e. Consistently strong support plans—including building from the Integrated Assessment, stating clear goals based on the resident's aspirations with the addition of staff expertise, and all team members' interventions (not just clinicians) stated specifically--is being monitored to determine full compliance.

"Goal Writing and Support Plans in the New York Model" provides specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and validating them as they talk about the outcomes they want; building on strengths to achieve their goals is stressed as an important part of writing support plans.

Helpful strategies are necessary for all Taberg staff to assist residents in being able to safely explore trauma-related goals, such as "Understand anger from the past that I can't control" or "Figure out why someone telling me 'No' reminds me of things in the past."

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 53a-f (12/14)

The MH Monitor observed two excellent Taberg support team meetings, both demonstrating sensitive relationships with girls and beneficial involvement of CMSO and parent in one.

[redacted] is the [redacted], a 14-year old at Taberg more than nine months for petit larceny. One of her mother's partners went to prison for sexually abusing one of her siblings, and [redacted]s sexualized behaviors started when she was young. Her mother moved from state to state during her childhood. In [redacted] she went to a residential placement at age 10 and spent more than a year in a juvenile facility at age 12. Soon after her mother moved with six children to [redacted] New York, she filed a PINS petition for [redacted] and before she was placed at Taberg, she was in a psychiatric hospital. Her Integrated Assessment is thorough and her clinician's summary in her IIP was very informative (see page 26 of this report): '[redacted] is a 14-year old with a long history of complex trauma. She has made great strides and shown a high level of bravery in attempting to create a life that is safe." Her support plan described that she had "struggled significantly during this period after alleging that her mother was involved in sexually trafficking her. In making the report she was aware that she was obstructing her release. Feelings of guilt for betraying her family. Increased violent outburst to staff as she feels she made the right choice then feels that a life of being sexually and physically maltreated is normal for her. Has made big strides in school." Her goals were: Goal #1 Wants to get a high school diploma. Clinician will discuss triggers, thoughts and feelings. Clinician will help YDA use updated IIP to help her with de-escalating and asking for time away. Goal #2 Wants to leave Taberg. Clinician will process how being unsafe during childhood might be a factor in her choice to exhibit unsafe behaviors. Clinician will help her practice self-soothing skills and use her safety plan. In her Psychiatrist Contact Note (11/24/14), her diagnosis was Disruptive Behavior Disorder (she was prescribed Benadryl for insomnia): "She has been restrained numerous times in the last few days. I asked if she was interested in trying a medication that might help with her recent increase in dysregulated behaviors. I suggested Abilify, and she quickly replied 'No.' She said 'Give me Seroquel.' I replied that I thought Abilify might offer more benefit with much less side effects and that if she changed her mind she should let nursing know. I called her mother and got consent for Abilify in case she changes her mind." Her support team included her clinician, YC, YDA, nurse, education coordinator, and computer lab teacher and there was positive interaction with her CMSO, discussing how to help her get to her goal of HGS therapeutic foster care. School staff reported she is intelligent and capable of doing work but her emotions get in the way. When [redacted] joined her

support team, she was shy and childish. She asked her YC to stop placing a call to her mother and she was able to say she did not want her in the support team meeting. Her clinician effectively engaged her in talking about her goals.

[redacted] is a 15-year old resident at Taberg five months for repeated assaults at a residential placement. Her Integrated Assessment was thorough. Her school behavior problems began in Kindergarten and in 3rd grade she was not taking medication prescribed for ADHD; her FS IQ was 78, below average. In 6th grade her FS IQ was 85, she was classified as learning disabled and was reading at the 3rd grade level and doing math at the 5th grade level. The MH Monitor observed her last support team before going home, with her clinician, YC, education coordinator, teacher, nurse, and Assistant Director for Treatment and the CMSO and her mother on the phone. Her clinician and CMSO reviewed their efforts to arrange services, particularly an addiction program, and communicate with her mother. A CSE meeting is being scheduled in the community and the Taberg educational coordinator plans to participate in person or by phone. The nurse updated the CMSO on psychiatric medicine prescriptions and other health concerns. Her clinician reported that [redacted] is taking her medication consistently and "realizes it has immediate effects; she is now able to talk about her anxiety." Her clinician was appreciative of her CMSO efforts to find community activities for [redacted] [redacted] support plan was incomplete, written in jargon she could not easily understand, and was not readily transferable to the community: Goal #1 To graduate from high school. The only intervention was her clinician meeting weekly with her to identify treatment interfering behaviors. Goal #2 To leave Taberg and return to her mother. The only intervention was her clinician providing weekly DBT groups. Her diagnosis was listed as Conduct Disorder and Cannabis Abuse although the psychiatrist was prescribing medication for ADHD and Conduct Disorder. When [redacted] joined her support team, she was pleased that her mother had called in to the meeting. Her clinician demonstrated a strong relationship with her. She smiled broadly when all the team members told her about her strengths. Her clinician said the team was meeting to help her apply her goals to the community. Her teachers gave her ideas for how to adjust to a new school. Her CMSO told her about a boxing program near her home (as she requested), and she was happy. In the debrief, her team expressed a desire to celebrate her great progress at Taberg. They realized that putting her goals and safety plan in a form that can be useful reminders to [redacted] and her mother, and involving her mother in that process, is essential in the week before she leaves.

As these residents demonstrate, Taberg support team meetings continue to be outstanding. Staff are working to make support plans unique for the resident and to specifically support each resident's individual process of trauma recovery. Goal-writing with girls is not easy, but it is crucial to support them in specifying "What has to change for you to be successful after Taberg?" The youth's answer to that question—for example, "figure out why I get so angry and learn not to" or "have better communication with my mother" or "feel like I can do better in school"—will also be the guide for how she will be successful at Taberg (not because her goal is program compliance but because what has to change for community success also has to change for success on the unit with peers and staff). The goal in improving support plans is not to have each part of the form in JJIS completed, but to have a document that is helpful to and used by the resident, all staff, her family and community supporters.

To ensure that Integrated assessments and support plans had individualized goals and detailed interventions by staff to help each resident meet her goals, in the four months since the MH Monitor's previous site visit (July, 2014), support was provided to Taberg by four BBHS staff: Ms. Rivera-Barrett visited the facility seven times (8/6/14, 8/19/14, 8/26/14, 9/10/14, 9/25/14, 10/16/14, 10/23/14), Ms. Lang visited the facility eight times (8/27/14, 9/3/14, 9/17/14, 9/24/14, 11/4/14, 11/5/14, 11/12/14, 11/13/14), the new Social Work supervisor Ms. King visited the facility 16 times (9/9/14, 9/16/14, 9/22/14, 9/30/14, 10/24/14, 10/30/14, 10/31/14, 11/3/14, 11/7/14, 11/10/14, 11/11/14, 11/17/14, 11/18/14, 11/24/14, 11/28/14, 12/1/14), and Dr. Tomassone visited four times (7/31/14, 8/14/14, 8/21/14, 8/28/14) as well as having weekly conference calls with clinical supervisors and bi-monthly NY Model Coaches conference calls. In November, one BBHS staff person was on-site at Taberg daily. They provided varied support: giving feedback on support teams and translating the meetings onto support plans, improving support plans, demonstrating DBT and Sanctuary groups, supporting staff in effectively using de-escalation, reviewing DBT with new clinicians, reviewing case files with clinicians, reviewing residents on Suicide Watch, transitioning new case managers onto the units, and JJIS documentation. A challenge in coaching staff to integrate DBT skills on the units everyday is that some clinicians were just getting their first training in DBT (with the DBT consultant).

The QAI Review (11/14) at Taberg observed a support team meeting in which staff had worked hard to develop a relationship with the youth. The meeting was thorough, strength-based, and supportive of the youth. All of the attendees were engaged and participated fully. The support team members were able to relate the youth's strengths to strategies for improvement in identified areas.

The QAI Review (11/14) at Taberg found that none of the reviewed support plans met standards: "The ISP is to be updated monthly in the Support Team Meetings. The purpose of the Support Team Meeting is to review and summarize the youth's current functioning; the youth's goals and objectives and progress towards such; identify each team member's role in assisting the youth in achieving objectives; and address new diagnostic treatment and progress as it becomes available; the ISP should also summarize the youth's response to mental health interventions; address suicide risk reduction and response, where applicable; and reflect the needs of the developmentally disabled/delayed, when appropriate. Most records did not have goals related to or documentation that substance abuse was being addressed. Suicidal issues during the month were not referenced in ISPs. Information from Integrated Assessments was not taken into consideration in developing ISPs. Team members did not have interventions." QAI required a plan to: (a) improve the timeliness of ISPs being completed at every support team meeting; (b) ISPs reflecting the team's consideration of the youth's Integrated Assessment; (c) all support team members offering an intervention to assist the youth achieve their goals; (d) ISPs including a detailed summary of the progress, or lack thereof made by the youth since the prior support team meeting; and (e) consistent documentation of all recent suicidal behaviors, as well as a response plan.

FUTURE MONITORING

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

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

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

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

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

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

COMPLIANCE

The OCFS substance abuse manual defines practices that comply with 54a. Taberg is providing InnerVisions groups for residents.

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

PARTIAL COMPLIANCE

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

Taberg had been providing Triad groups for residents but they were discontinued after the substance abuse clinician left in June, 2014.

Taberg clinicians must provide individual therapy regarding substance use for residents with a substance use diagnosis, and this must be reflected in goals, interventions, and progress in support plans. The MH Monitor did not see any records in which a clinician assisted a resident in completing a relapse prevention plan. Since substance use is a significant problem for residents, it is recommended that Taberg clinicians be provided with a supervision group led by a substance abuse treatment provider on strengthening the integration of substance use treatment (and connecting it with trauma) into individual and group therapy.

On Site Observations Regarding Paragraph 54a-b (12/14)

Many Taberg residents have a history of substance use noted in Integrated Assessments, but not reflected in goals in support plans. Applying skills being learned in the facility to successfully avoid returning to substances in the community should be an

ongoing goal of services documented in contact notes and support plans. Relapse prevention plans should be included in re-entry planning.

Like the process of becoming trauma-responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. A necessary element of coaching on New York Model implementation is ensuring that each resident integrates skills learned in substance abuse treatment with those learned in therapy and DBT and Sanctuary groups. Strong communication in support teams and Mental Health Rounds among the clinicians, YCs, and YDAs and the rest of the team is necessary to support each Taberg resident's individual progress in self-calming and relying on these skills to avoid substance use in the community.

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

The MH Monitor observed the first Triad group at Taberg in months, convened by the new Assistant Director for Treatment (who had previously worked in substance abuse treatment). The topic of the group was alcohol use and several residents actively participated. He was tolerant of two girls talking to each other and another walking around during part of the group, in the hope of involving --and not antagonizing--them. The complete substance abuse treatment program is anticipated at Taberg when the new substance abuse clinician begins.

The QAI Review (11/14) at Taberg found that Substance Abuse Programming scored within the Not Meeting Standards range overall. There were no comprehensive substance abuse evaluations completed, substance abuse treatment was not documented, and InnerVisions curriculum sessions were inconsistently held. QAI required a plan to ensure follow-up after preliminary assessments (AADIS) are conducted and/or upon admission with an assigned SNAP score of 3.0 or higher and provide substance abuse treatment services for these youth.

FUTURE MONITORING

The MH Monitor will continue to review evidence that all youth with substance abuse diagnoses at Taberg are receiving individual (minimally twice per month) and group (minimally once per week) substance abuse treatment (not only InnerVisions).

The MH Monitor will continue to review documentation that substance abuse assessment results are in Integrated Assessments, incorporated in the goals and interventions on their support plans, including a relapse prevention plan, and in their

Community Re-Entry plans and that youth are receiving substance abuse treatment in individual therapy reflected in clinical contact notes.

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

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

COMPLIANCE

The Continuity of Care Plan complies with 55a.

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

PARTIAL COMPLIANCE

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

The new Community Re-Entry Plan complies with 55b.

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

Taberg has not started using the Community Re-Entry Plan.

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 55a-c (12/14)

The Community Re-entry Plan was finalized in JJIS in May 2014. Like support plans, the clinician, case manager, medical, education, and CMSO each submit their part of the Community Re-Entry Plan. The goals of the youth during the transition to the community are entered, with the services to be provided in the community, including the ACS/DSS-permanency plan for where the youth will live. The Community Re-Entry Plan is designed

to consolidate information from the Integrated Assessment, support plan, and other sources (plus the current IEP, transcript, and other school and vocational information to be provided to the youth's next school). A major purpose of the last support team meeting before transition and of the Community Re-Entry Plans is to transfer the resident's goals to the community, so supporters in the community understand their role in helping the youth regulate emotions, tolerate distress, and avoid relapsing.

Taberg staff were supposed to be trained on the Community Re-entry Plan by the fall, 2014. The MH Monitor was informed about the delay in training on Community Re-entry Plans due to extended medical leave by the trainer. At the time of the site visit, CMSO staff were being trained in Community Re-entry Plans and were directed to start doing the CRPs in JJIS in December, 2014. The Taberg Assistant Director for Treatment was scheduled for Community Re-Entry Plan training in mid-December, followed by the clinicians. Taberg was expected to complete Community Re-entry Plans by February, 2015.

As Taberg staff begin to do Community Re-entry Plans, it is essential that completing the form does not obscure their exemplary efforts to facilitate each girl's success in the community. The Community Re-entry Plan must be a document that can be easily referred to for guidance about how to support a girl in the community. Goals from her facility stay must be translated into goals that are meaningful in the community. The course of treatment section of her Community Re-entry Plan must be written in a way that would help her, her parent and her CMSO use the skills she learned at Taberg to cope successfully with challenges at home and community school. The background information section of her Community Re-entry Plan should link trauma history to behaviors and emotional regulation in a way that is understandable to family and service providers.

One recently-discharged resident demonstrates the transition work by Taberg staff that hopefully will be captured in Community Re-Entry Plans:

[redacted] is an intelligent 14-year old diagnosed with PTSD and substance abuse whose support team the MH Monitor observed at Taberg in July, 2014. In October, 2014, after eight months at Taberg, [redacted] was transferred to [redacted] where she remains. Her extensive trauma history includes exposure to parental substance abuse and domestic violence as well as sexual, physical and verbal abuse and repeatedly moving between her mother's and [redacted] home. Her substance abuse and running away were recognized as self-destructive coping mechanisms. [redacted] made false allegations of sexual abuse, had numerous suicide watches and defecated on the floor, spit and threw feces at Taberg in early 2014. In July she decided to stop these behaviors, and substance abuse treatment in the context of effective trauma recovery was encouraged, including preparing for living in the community without relying on substances to numb her feelings and past memories. Her last support plan at Taberg (September, 2014) included goals that were transferable to her next placement: Goal #1: Discharge from current placement. (Her clinician will help her practice DBT skills and make connections between past trauma and explosive anger; YDAs will help her before she escalates); Goal #2: Maintain her sobriety (her clinician will continue to explore the role of marijuana on coping with internal distress linked to her experiences of childhood maltreatment; her mentor will meet with her weekly to develop adaptive coping strategies when she is feeling overwhelmed. Goal #3: Create a safe environment for herself to flourish in by refraining from self-injurious

behavior and altercations with others (display the use of mindfulness when she becomes angry; her clinician will continue to discuss putting herself at risk by engaging in dangerous relationships and learning to be cared about in a healthy fashion). [redacted] CoC referred her for mental health counseling, family therapy, substance abuse treatment and psychiatric services (she was prescribed Trazodone and Celexa) at [redacted]. In contrast to other CoCs, [redacted] CoC included an informative discharge summary: "Youth's mental health treatment needs and medical and educational needs have been clearly communicated with [redacted]. She will be enrolled in high school and receive tutoring for subjects such as math. She will be seen by a psychiatrist who will provide her with medication as necessary. She will also receive both individual and group therapy for issues related to her substance abuse and history of trauma. [redacted] also reported that they are willing to continue to engage her mother in treatment while offering family therapy [so her mother can be] a strong support who is able to attend to her unique treatment needs in the future. She will have the opportunity to participate in various extracurricular activities, sports, and vocational training. She seems excited about the opportunities presented to her and is able to discuss being able to benefit from the wide variety of services provided. She is able to admit that she does not feel that going home to her mother is in her best interest as she wants to progress in her education in order to begin to envision a more productive life…[and achieve her] long-term goals of remaining substance free and attending college."

Systemic placement problems continue to reduce Taberg's effectiveness. At the time of the site visit, there were at least five residents who were not typical delinquents and, due to trauma-related behaviors, had been sent to RTCs where their needs were not met and their reactivity in the program led to their placement at Taberg. The systemic response to these girls should instead be to intensify services at a residential program specifically designed to treat trauma. For some other girls, two systemic improvements were announced at this site visit: Cayuga now has a treatment foster care program for OCFS youth, and two Taberg girls were recently placed. In addition, Mercy First and Cayuga converted diversion beds into transitional beds in community-based programs that Taberg girls may be referred to.

FUTURE MONITORING

The MH Monitor will review documentation that Taberg produces thorough Community Re-Entry Plans in JJIS that, along with Continuity of Care plans, support the continuation of the resident's progress in the facility in the community.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. Document Development and Revision. Consistent with paragraph 68[1] of this Agreement, the State shall create or modify policies, procedures, protocols, training curricula, and practices to require that they are consistent with, incorporate, address, and implement all provisions of this agreement. In accordance with paragraph 68 of this Agreement,

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

the state shall create or modify, as necessary, other written documents – such as screening tools, handbooks, manuals, and forms – to effectuate the provisions of this Agreement. The State shall submit all such documents to the United States for review and approval, which shall not be unreasonably withheld.

COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Taberg Residential Center for Girls* (November 26, 2014) (also referred to as the QAI Review of Taberg) and had an opportunity to discuss its contents and findings before the Taberg monitoring visits. Again, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors. The quality of QAI products has become an important source of information in the monitoring process. The quality of the QAI Reports has been excellent. The reports have been thorough and informative.

Over a year ago, QAI implemented the Graduated Response System (GRS) as a quality assurance tool, incorporating performance metrics developed with the assistance of OCFS' Bureau of Strategic Planning and Policy Development. QAI reviewed with the Monitors the development of these restraint metrics and how they will be linked to GRS protocols and action plans. More importantly, this QAI initiative recognized that reliable critical performance metric/restraints safeguards influence the monitoring in ways that expedite agreement among the Parties about compliance. GRS validation requires verification that GRS works more than once.

At its optimum, GRS anticipates and alerts staff at the Home Office and facility levels of impending changes so that appropriate corrective or preventive actions can be taken. The GRS parallels the latest, best peer-reviewed statement of generally accepted professional standards for quality assurance as described in the recent joint publication of the National Institute of Corrections (NIC), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the National Partnership for Juvenile Services (NPJS). GRS serves as an excellent mechanism at the facility and Home Office levels to monitor and alter variations in use of force activities. The Intact Teams (by more than their Red Flag meetings for their unit) have become an essential element in the use of the GRS, serving as a primary agent for problem-solving and stability regarding Protection from Harm and Mental Health programs in the living units.

Reducing the time between the discovery of a problem and its resolution also increases the likelihood of successful outcomes. Empowering the Intact Teams strengthens

GRS, particularly with real time week-by-week data analysis for each Intact Team meeting so (a) the Intact Teams recognizes when the unit was in the green and (b) the Intact Teams can immediately generate new interventions if the weekly data go into yellow. Looking at data from the previous month can be a delay for initiating a corrective intervention. The Intact Teams, sensitive to the individual youth variables (e.g., a new youth has arrived, a youth gets bad news, a conflict from the street emerges), develop immediate strategies such as one-on-one, intensified mentoring, etc. to fit the youth. This aspect of GRS needs strengthening, and the Monitors recommend a renewed emphasis on Intact Team access to real-time restraint data.

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

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: A crisis of the nature of the rash of staff sexual abuse allegations should initiate discussions about the role of special additional QAI critical reviews and evaluations of the OCFS crisis management plans.

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

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

V. SUMMARY

Taberg staff should be commended for their patience and perseverance. They came together in adversity and continue to be committed to returning to a therapeutic, safe, and stable environment. Since the spring of 2014, during a stressful, extended crisis that affected them all, Taberg staff have maintained a professional demeanor and displayed a remarkable resilience.

At the beginning of 2014, QAI noted a strong administrative team, improved stability, increasing staff skills in supporting residents' emotional regulation, and reduced

uses of force at Taberg. Following months of unsubstantiated sexual abuse allegations, in December, 2014, Taberg was showing signs of recovery and re-creating a safe environment where residents could make progress.

There are too few Taberg staff for 24 challenging residents. Many staff are working long hours which makes them less effective. The continuing high number of restraints and suicide watches are indicators of instability in the units.

Taberg is full and all the girls are extremely needy trauma victims who continually try to engage staff in control battles. Most of the girls on both units have challenging behavior driven by trauma and many do not have a re-entry placement likely to provide permanency and adequate support to continue the progress they make at Taberg.

It is good news that Taberg expects to have its full clinical team for the first time. Operating Taberg as a single mental health-focused program will make it possible for all the girls to benefit from services provided on a Mental Health Unit. Nevertheless, the shortage of YCs and the lack of an Assistant Director for Program remain serious problems at Taberg. Staff were understandably worn out, and even with new hires, it will be a continuing stretch for talented staff if both units remain full of high needs residents. It takes a large number of skilled staff to provide the 1:1 attention and support for self-calming necessary in a unit of 12 girls who constantly trigger each other.

Taberg underscores the importance of fully integrating the Mental Health and Protection from Harm aspects of the Settlement Agreement. Improving support plans, strengthening individual trauma treatment, incorporating DBT and Sanctuary in unit life, effective substance abuse treatment and relapse prevention plans, and strong Community Re-Entry Plans are important. Taberg staff are working to enhance their skills at responding to the troubling behaviors of traumatized girls. It is essential to have a full clinical and YC team so residents get the mental health treatment to meet their needs and that clinicians and YCs are able to support, coach, and debrief with YDAs and others who do most of the intervening with residents. Better de-escalation strategies, richer staffing to permit enhanced coaching, and strong intact teams continue to be necessary for full implementation of the New York Model at Taberg.

Endnote

[1] To test the null hypothesis regarding differences between the mean monthly data for variables in Array1 (7 months prior to the onset of staff sexual abuse allegations) and Array2 (9 months following the onset of staff sexual abuse allegations), the PH Monitor used the formula function of Excel to return the probability associated with a Student's t-Test.

Excel TTEST Syntax

Argument	Description	Remarks
Array1	The first data set.	OCFS data for the seven months preceding the onset of the staff sexual abuse allegations (July 2013 through January 2014).
Array2	The second data set.	OCFS data for nine (9) months following the onset of the staff sexual abuse allegations (February through October 2014).
Tails	Specifies the number of distribution tails or the number of directions the differences in the means might be.	If tails = 2, TTEST uses the two-tailed distribution. In this case, we assume the means in Array2 could be larger or smaller than Array1, so a two–tailed distribution is selected.
type	The kind of TTEST to perform.	If type equals 3, TTEST performs a two-sample unequal variance (heteroscedastic) test.

Data Category	**Array1 Pre** *n* = 7	**Array2 Post** *n* = 9	***t*-test** *p*<
Physical Restraint Rate per 100 Bed Days	4.15	8.02	0.00
Percent of Youth Involved in a Restraint Event	32.30	57.44	0.00
Total Days Care	615.43	666.56	0.02
Injury Non-Accidental	7.14	6.33	n.s.
Suicide Events	4.43	10.00	0.02
Suicide Events with Injury	1.14	1.56	n.s.