U.S. Department of Justice v. The State of Ohio

Civil Action No: 2:08-cv-475

Monitor's Third Report on the Amended Stipulation signed June 28, 2011

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INTRODUCTION

On June 4, 2008, The United States Department of Justice (DOJ) and the State of Ohio (the State) signed a stipulation for injunctive relief (the Stipulation) concerning conditions at the Scioto Juvenile Correctional Facility (Scioto) and the Marion Juvenile Correctional Facility (Marion; which was closed shortly after the Stipulation was signed). Fred Cohen, the Lead Monitor of the concurrent conditions of confinement lawsuit, *S.H. v Reed et al*., served as the monitor for the Stipulation until late 2009. At that point, Mr. Cohen resigned and the DOJ assumed the role of Monitor, with Dr. Kelly Dedel, Dr. Daphne Glindmeyer, and Dr. Michelle Staples-Horne serving as subject matter experts.

In June 2011, as the original stipulation expired, the Parties recognized that the State had not yet reached substantial compliance with several key portions of the Stipulation. Thus, the Stipulation was renegotiated to include a subset of the original provisions. The Amended Stipulation terminates when the State has achieved substantial compliance with each provision and has maintained substantial compliance for two reporting periods (i.e., 12 months). The Parties also agreed that the Amended Stipulation is subject to the termination provisions of the Prison Litigation Reform Act.

The Monitor for the Amended Stipulation is Dr. Kelly Dedel, who evaluates the State's progress in the areas of Protection From Harm, Grievances, Programming and Special Education. She is assisted by two Subject Matter Experts, Dr. Daphne Glindmeyer, who evaluates the State's progress on provisions related to Mental Health Services, and Dr. Michelle Staples-Horne, who evaluates the State's progress on provisions related to Medical Care.

As the Monitor, Dr. Dedel is the primary liaison between the Monitoring Team and the Parties and she compiles the Monitor's Report. To do so, she combines Drs. Glindmeyer's and Staples-Horne's reports with her own to form a coherent whole, but does not change the substance of the reports by either of the Subject Matter Experts, who are responsible for forming their own opinions about the level of compliance for each provision in their areas of expertise.

This is the Monitor's third report on the State's progress toward the reforms required by the Amended Stipulation. The monitoring period is April 1 through September 30, 2012. Progress reports are issued approximately every six months.

EXECUTIVE SUMMARY

The Amended Stipulation includes 33 provisions related to Protection From Harm (n=3); Grievances (n=2); Programming (n=2); Mental Health Care (n=18) and Documentation (n=2); Medical Care (n=3); and Special Education (n=3). Each provision is listed in the table below, along with the Monitor's or Subject Matter Expert's compliance rating.

The Monitor's first report used only two compliance levels: substantial compliance and non-compliance. The subsequent reports use a three-tiered system (substantial compliance, partial compliance and non-compliance), defined as follows:

- ***Substantial Compliance*** means that the facility has drafted relevant policies and procedures; has trained the staff responsible for implementation; has sufficient staff to implement the required reform; has demonstrated the ability to properly implement the procedures during the majority of the monitoring period; and has ascertained that the procedures accomplish the outcome envisioned by the provision. Non-compliance with mere technicalities or a temporary failure to comply (due to staff vacancy or illness, facility disruptions, or other short-term events) during an otherwise sustained period of compliance do not constitute a failure to achieve or maintain substantial compliance. Conversely, temporary compliance during a period of sustained non-compliance or partial compliance does not constitute substantial compliance.

- ***Partial Compliance*** means that the facility has drafted policies and procedures, has trained staff responsible for implementation, and has sufficient staff to implement the required reform. While progress has been made toward implementing the procedures described by policy, performance has been inconsistent throughout the monitoring period and additional modifications are needed to ensure that procedures are sufficiently comprehensive to translate policy into practice.

- ***Non-Compliance*** means that the facility has made only very preliminary efforts to implement the required reform, but significant work remains. Policy may need to be overhauled, the majority of staff may need to be trained, procedures may not have been developed, and no one has begun to ascertain whether the procedures accomplish the outcome envisioned by the provision.

The Monitor wants to emphasize that the substantial compliance rating is given only when the required reforms address all of the issues discussed in the Provision and when solid implementation of the reforms has been consistently demonstrated, through reliable data, observations and reports from staff and youth, for a majority of the monitoring period. Partial compliance indicates that some of the issues addressed in the Provision have been resolved, but that problems, some of them serious, still remain. The application of the partial compliance rating is only a brief indicator—the entire discussion should be read to fully understand the type and magnitude of remaining problems.

Table 1. Compliance Ratings for Each Provision				
No.	Provision	1st Report	2nd Report	3rd Report
Protection From Harm				
III.A. 1	General Protection From Harm	NC	PC	PC
III.A.3	Seclusion	NC	PC	PC
III.A.5	Investigation of Serious Incidents	SC	PC	PC
III.D.1	Grievances	PC	PC	PC
III.D.2	Grievances Explained to Youth	PC	SC	SC
III.F.1	Structured Programming	NC	NC	PC
III.F.2	Orientation	PC	PC	PC
Mental Health Services				
III.B.1	Mental Health Screening	PC	PC	SC
III.B.2	Immediate Referral to QMHP	PC	PC	SC
III.B.3	Identification of Previously UnID Youth	NC	PC	PC
III.B.4	Mental Health Assessment	NC	PC	PC
III.B.5	Adequate Care and Treatment	NC	PC	PC
III.B.6	Treatment Planning	NC	PC	PC
III.B.7	Treatment Teams	PC	PC	PC
III.B.8	Integrated Treatment Plans	NC	PC	PC
III.B.9	Access to QMHP	NC	PC	SC
III.B.10	MH Involvement in Housing and Plcmt	NC	PC	PC
III.B.11	Staffing	NC	PC	PC
III.B.12	Medication Notice	PC	PC	PC
III.B.13	Mental Health Medications	PC	PC	PC
III.B.14	MH/DD Training for Direct Care Staff	NC	NC	NC
III.B.15	Staff Mental Health Training	PC	PC	PC
III.B.16	Suicide Prevention	PC	PC	PC
III.B.17	Transition Planning	PC	PC	PC
III.B.18	Oversight of Mental Health	NC	NC	NC
III.G.1	Progress Notes	PC	PC	PC
III.G.2	Accessibility of Information	NC	NC	NC

Medical Services				
III.C.1	General Medical Care	SC	PC	PC
III.C.2	Health Records	SC	PC	PC
III.C.5	Access to Health Services	SC	SC	SC
Special Education Services				
III.E.1	Provision of Special Education	PC	PC	PC
III.E.7	Individual Education Plans	PC	PC	SC
III.E.8	Vocational Education	NC	NC	SC

Overall, the State is in substantial compliance with 7 of the 33 provisions (21%, compared to 6% during the previous monitoring period), in partial compliance with 23 provisions (70%; compared to 79% during the previous monitoring period) and in non-compliance with 3 provisions (9%, compared to 15% during the previous monitoring period). Across the 33 provisions, the compliance rating was upgraded for 6 provisions (18%). The compliance rating was not downgraded for any provision. Compliance ratings for each section and key issues to be addressed are highlighted below.

Protection from Harm (includes Grievances and Programming)

The facility is in substantial compliance with 1 of the 7 provisions (14%) related to protecting youth from harm and in partial compliance with the remaining 6 provisions (86%). The following actions should be prioritized:

- Conduct a problem-solving analysis to determine the nature of youth-on-staff assaults and implement interventions that target the underlying causes and patterns.
- Improve the quality of FIA reviews of the use of physical restraint to ensure that staff have exhausted all other means for resolving problems with youth. Ensure that staff are provided with coaching to help develop their skills in this area and to ensure their compliance with all related policies.
- Ensure that sufficient direct care staff are recruited, hired and retained in order to reduce the reliance on mandated overtime to meet minimum staffing requirements.
- Reinforce the prohibition against provoking, taunting, belittling and otherwise disrespecting youth. Investigate complaints vigorously and enforce the conduct standards when they are violated.
- Modify the IRAV to ensure that youth remain in pre-hearing seclusion no longer than necessary to de-escalate their behavior and ensure they do not pose a threat to the safety of other youth and staff. Ensure that Intervention Hearings are held in a timely manner.
- Limit the use of intervention seclusion, relying instead of sanctions that provide an opportunity for skill development and treatment in order to create behavior change, and collect data to demonstrate the extent to which this has occurred. Develop quality

assurance mechanisms around the use of seclusion in Intervention Hearings and to determine whether the IDT sanctioning process is a viable strategy for reducing the reliance on seclusion and increasing safety.

- Ensure that youth on the PROGRESS Unit are not scheduled to be in their rooms in any greater measure than youth in the general population.
- Ensure that youth on the PROGRESS Unit are out of their rooms, attending treatment education or other structured programming throughout the day. This programming must be delivered with integrity so that the youth are able to meet their treatment goals and return to the general population within a reasonable period of time.
- Finalize the PROGRESS Unit policies, SOP and Youth Handbook so that they provide an accurate description of the current operation of the Unit. Revise these documents as the program evolves.
- Reduce the number of individuals authorized to conduct facility-based investigations and ensure that these individuals have the requisite skills for the task. Ensure that producing timely, high-quality investigations is a specific job responsibility and that employees are held accountable for their failure to produce reports that meet professional standards.
- Promptly notify youth of the outcome of any grievance referred for investigation. Construct a plan to respond to the problems discovered by the CIO's 2011 grievance survey.
- Ensure that individual and group treatment is delivered at the required frequency and duration on all units.

Mental Health Services

The facility is in substantial compliance with 3 (15%) of the 20 provisions related to mental health services and documentation. It is in partial compliance with 14 (70%) of the provisions and in non-compliance with 3 of the provisions (15%). The following actions are required:

- Finalize and implement policies. ODYS has recently completed a collaborative policy and procedure review and revision process. The Monitors in both this case and S.H. v. Reed have reviewed these policies.
- Staff the facility with sufficient psychiatric (both psychiatric physicians and psychiatric nurses) resources to provide psychiatric evaluation, medication monitoring, and treatment team interaction.
- Develop an organized training schedule for mental health staff.
- Train direct care staff and mental health staff to understand the behavior and needs of youth with mental illnesses and developmental disabilities and recognize and respond to signs and symptoms of serious mental illness.
- Train mental health staff to develop high-quality case conceptualizations that integrate the information generated by the multiple assessments administered to youth upon admission.
- Train, coach and adequately supervise direct care staff and mental health staff to implement the Phoenix New Freedom curriculum, particularly in skills for leading group therapy sessions to ensure the interactions and documentation reflect generally accepted practices for mental health care. This should include treatment integrity

checks (e.g. observation of group interaction with subsequent education and training as necessary).

- Develop procedures to ensure, and to document, that youth are assessed by a qualified mental health professional within 12 hours when a serious risk to the youth's safety is identified.
- Ensure mental health staff assesses youth on suicide precautions, those in seclusion, and those on the PROGRESS Units every 24 hours.
- Ensure youth with acute mental illnesses requiring extensive mental health treatment have access to more appropriate placements.
- Ensure treatment plans are individualized including measurable goals and targeted interventions to address the goals. Update treatment plans regularly and monitor youth's progress toward achieving treatment goals. Adapt treatment plans for youth who are not progressing.
- Ensure Interdisciplinary Treatment Team meetings include representatives from the major sectors of the facility including social workers, direct care staff, educators, and psychiatrists and that Treatment Teams are focused on treatment issues and the youth's progress toward treatment goals.
- Ensure youth on the PROGRESS Units are appropriate for the secure setting and receive appropriate treatment. Conduct thorough assessments of all youth proposed for placement in the future.
- Continue the current practice of assigning all youth housed in the PROGRESS Units to the mental health caseload.
- Ensure youth receive proper laboratory examinations and side-effect monitoring commensurate with the psychotropic medications prescribed and reflecting generally accepted practices.
- Develop a coherent, coordinated quality assurance process that provides a cogent review of social work, psychological and psychiatric services at the facility. This should include peer review. It should also include both process and outcome measures with corrective action inclusive of individual supervision, staff training, or adjustment of systems as necessary.
- Address limitations to treatment resulting from the fragmented recordkeeping process via the creation of a unified record.

Medical Services

The facility is in substantial compliance with one of the provisions (33%) related to medical services and in partial compliance with the other 2 provisions (66%). The following actions should be prioritized:

- Complete satellite clinic and medication room on Buckeye Units for adequate injury assessments of youth and medication administration on the unit.
- Limit time of youth in seclusion and improve documentation of health status during segregation.
- Continue to improve Quality Assurance (QA) activities by considering a review at least annually by a source external to ODYS Health Services. ODYS should also consider expansion of the QA process to include some additional quality indicators. Conduct

Quality Assurance Program as outlined in the National Commission on Correctional Health Care Juvenile Health Standards. This would satisfy the need for a self-assessment.

- Continue to improve the process for sharing of health information between medical and mental health to include psychologists through implementation of eClinical Works EHR. ODYS medical management staff should be intimately involved in the process of customization of the EMR to be relevant to youth medical services.

Special Education

The facility is in substantial compliance with 2 of the 3 education-related provisions (66%) and is in partial compliance with one provision (33%). The following actions should be prioritized:

- Address the preventable causes of absenteeism, address data entry and data management issues, and ensure average attendance rates of 85% or better are achieved for each housing unit.
- Continue to provide access to alternative education services for youth in seclusion through the use of Unit Instruction. Ensure that the type, quality and duration of instruction comply with the *S.H.* Parties' agreement. Come to an agreement with the *SH* Parties as to whether youth will be served behind their doors or may be brought out into the dayroom, when that can be accomplished safely.

The facility has undergone several transformations since the original Stipulation was signed. Originally, Scioto was the central reception facility for all DYS facilities. In the summer of 2011, DYS began to de-centralize its reception process to convert Scioto to a long-term facility that houses medium and close custody boys. Scioto remains the reception center for girls and also operates a long-term girls' program and a mental health unit for girls. The facility also houses a special management unit (the PROGRESS Unit), which has been the topic of much controversy during the current monitoring period.

The change in the facility's mission required staff to adjust to a new type of youth (generally higher-risk) and to new responsibilities for their long-term care and treatment. In addition, the facility received an entirely new Administrative Team in February 2012, and then received a new Superintendent in September 2012. The multitude of changes have made steady progress toward substantial compliance difficult to achieve.

The remainder of this report is organized as follows: 1) each Provision is presented, verbatim; 2) the compliance rating is noted; 3) information the State presented to demonstrate compliance with the Provision is summarized; 4) additional activities undertaken by the Monitor or subject matter expert to determine the level of compliance are discussed; 5) the steps required to achieve substantial compliance with the Provision are listed; 6) the sources of information the Monitor or subject matter expert used to form her opinion are listed.

PROTECTION FROM HARM

III.A.1 General Protection From Harm. The State shall, at all times, provide youth in the facilities with safe living conditions. As part of this requirement, the State shall take appropriate measures to ensure that youth are protected from abuse and neglect, use of excessive force, undue seclusion, undue restraint, and over-familiarization.	
Compliance Rating	Partial Compliance
Self Assessment	The State provided an array of data to illustrate the trends in youth violence, restraints, seclusion, and allegations of employee misconduct, along with an interpretation of the trends and the underlying causes of any changes. The structure of the Monitor's most recent visit did not provide as much time to discuss the interpretation of the data as in previous monitoring periods. As a result, much of the following discussion is based on the Monitor's own analysis but is contained in the self-assessment section for the sake of clarity. While on site, the Monitor learned of several quality assurance mechanisms that, if data are interpreted properly and used as a basis for action, will improve the State's ability to protect youth from harm. Trends in youth violence, restraints, and allegations of over-familiarization are discussed here, while detailed discussions about the use of seclusion and staff misconduct can be found in III.A.3 and III.A.5 respectively. *Youth Violence* The table below presents the rate of youth-on-youth and youth-on-staff violence for the past 18 months. These data reveal a steady reduction in youth-on-youth violence. The average rate for the past three six-month monitoring periods was .24, .13 and .08. Changes in the rates of violence are customarily related to a complex constellation of factors including staffing, programming, treatment, the type of youth housed, amount of idle time, and the staff's skill at de-escalating the tension that arise. Most recently, the facility attributed its lower rates of youth-on-youth violence to changes in staffing. Specifically, permanent assignments were made for both the Operations Administrator and Unit Management Administrator, who worked and collaborated on daily issues and used proactive approaches to ensure that youth were protected from harm. In addition, since March 2012, all units have had a Unit Manager. Finally, the facility did not operate below minimum staffing levels at any time during the current monitoring time. [Recall that short staffing was identified as a major contributor to a variety of operational problems in the 2nd Monitor's Report.] In addition, the PROGRESS Unit (PU) school was identified as a hot spot for youth-on-youth violence. The level of surveillance in the school was

drastically increased to include five Youth Specialists to assist with school movement and support during school hours. Support for this change was offered by nearly everyone with whom the Monitor spoke while on site, and it is strongly recommended that the State take steps to ensure that this level of staff support is permanently available. [Currently, the five YSs voluntarily leave their assigned posts to provide this assistance.] In addition, the school environment was "hardened" by bolting down furniture and computers and replacing keyboards that youth had been using as weapons.

Youth violence also tended to occur among the close custody youth during 2nd shift. As discussed in the review of structured programming in Provision III.F.1, the Gang Intervention Specialist began running groups with this population in the afternoons and has been more present on the units during the evenings and weekends. Finally, recreation staff and Youth Specialists have collaborated to provide additional programming opportunities to youth on the weekends to reduce the amount of idle time. All of these efforts appear to have accomplished the intended objective of reducing the rate of youth-on-youth violence.

Youth Violence, April 2011 through September 2012						
Month	Youth-Youth			Youth-Staff		
	#	ADP	Rate	#	ADP	Rate
Apr 11	30	128	.23	13	128	.10
May 11	40	114	.35	14	114	.12
June 11	25	110	.23	13	110	.12
July 11	19	101	.19	9	101	.09
Aug 11	24	108	.22	15	108	.14
Sept 11	29	138	.21	45	138	.33
Oct 11	31	164	.19	29	164	.18
Nov 11	29	161	.18	29	161	.18
Dec 11	18	159	.11	11	159	.07
Jan 12	21	158	.13	30	158	.19
Feb 12	10	137	.07	19	137	.14
Mar 12	9	125	.07	21	125	.17
Apr 12	9	118	.08	31	118	.26
May 12	11	101	.11	16	101	.16
June 12	4	91	.04	14	91	.15
July 12	10	83	.12	18	83	.22
Aug 12	11	88	.12	22	88	.25
Sept 12	1	86	.01	14	86	.16

	Unfortunately, the rate of youth-on-staff violence has been more resistant to change. The average rate of youth-on-staff violence has actually increased about 30% over the past three monitoring periods (1st monitoring period = .15; 2nd monitoring period = .16; and 3rd monitoring period = .20). Previous discussions with facility administrators centered around the belief that the largest contributor to the rate of youth-on-staff assaults was the throwing of bodily fluids and other liquids on staff in the PU. The use of container-less meals (where youth receive the same food, but it is served without cups or cartons, trays with hard dividers or other structures that youth could use to store liquid to be used as a projectile) was said to significantly decrease the frequency of this behavior. While the number of these types of assaults has indeed declined, the rate of youth-on-staff assaults remains high, indicating that other types of youth violence against staff need to be addressed. The recent efforts to increase staffing levels and shore up the security of the classroom environments on the PU should be assessed for their impact on youth on staff violence. If the desired results are not being obtained, the facility should undertake a facility-wide problem-solving analysis to specify the types of assaults (e.g., unprovoked physical assault versus assault that occurs while resisting a physical restraint), the severity of these assaults, the places and times where they occur, and the characteristics of the youth involved (e.g., are they gang-related assaults; are the youth on the mental health caseload; what skills do the youth and staff lack for managing their behavior appropriately?), and the general demeanor of staff involved (did they somehow provoke the youth or otherwise escalate the incident?). Once more is known about the nature of the problem, the facility should launch targeted interventions designed to address these specific causes and features of the problem. For example, throughout the Monitors' interviews, youth reported frustration with certain staff who were described as antagonizing, provoking, and otherwise speaking and behaving in ways that could increase youth's propensity for violence toward them. This solution to this problem has many facets, including skill development among youth to tolerate frustration, make requests appropriately, control impulses, etc. along with reiterating and enforcing requirements around appropriate behavior and demeanor among staff, teaching them skills for tolerating their frustrations with youth, and holding them accountable for failing to meet these standards. *Use of Restraints* The previous Monitor's Report registered concern about the use of physical restraints. Restraint use was very high at the beginning of the

previous monitoring period, but had begun to decrease during the last half of the previous monitoring period.

The use of physical restraints decreased slightly during the current monitoring period. The average rate of restraint for the total population during the previous monitoring period was .72, compared to .62 for the current monitoring period. However, looking only at the total population masks the significant gender difference and thus obscures an area that is ripe for a problem-solving effort.

Nearly all of the decrease in the use of physical restraint can be attributed to the decreases witnessed among the female population at Scioto. Although the girls had a higher average rate across the current 6-month period (.73 versus .58), the patterns across the months tell a different story. The boy's rate of restraint remained relatively constant, at .45 or higher. However, the girls' rate of restraint decreased significantly throughout the monitoring period, from a high of 2.08 at the beginning of the period down to .08 at the end of the period. Most likely, this can be attributed to the reduction in the size of the girls' mental health population. While the use of a rate controls for changes in the size of the population, it does not account for the differing management issues that come with serving a population with serious mental health issues.

Physical Restraints, January through September 2012

Month	Total			Males			Females		
	#	ADP	rate	#	ADP	rate	#	ADP	rate
Oct 11	150	164	.91	103	128	.81	47	36	1.31
Nov 11	177	161	1.10	111	128	.87	66	33	2.00
Dec 11	99	159	.62	49	124	.40	50	35	1.43
Jan 12	93	158	.59	61	125	.48	32	33	.97
Feb 12	88	137	.64	50	106	.47	38	31	1.23
Mar 12	59	125	.47	34	97	.35	25	28	.89
Apr 12	94	118	.80	40	92	.43	54	26	2.08
May 12	55	101	.54	35	77	.45	20	24	.83
Jun 12	52	91	.57	36	68	.53	16	23	.70
July 12	70	83	.84	60	64	.94	10	20	.50
Aug 12	51	88	.58	48	72	.67	3	16	.19
Sep 12	35	86	.41	34	75	.45	1	12	.08

The facility should be applauded for its efforts to move girls with serious mental health issues to a more appropriate setting, but the Monitor

	remains concerned that the use of physical restraint among the boys' population at Scioto has not shown much improvement over the past 12 months. This is not to say that staff should not restrain youth who pose a legitimate threat to the safety of other youth, staff or themselves, but rather that the facility as a whole needs to better address the underlying causes of their misconduct and distress that leads to the restraint. A comprehensive internal and external quality assurance process has been in place for several years, and should be engaged to determine whether opportunities exist to reduce the need for restraints (i.e., whether incidents could be better handled before escalating to the point of needing a restraint to ensure staff or youth safety). The Facility Intervention Administrator (FIA) is responsible for reviewing every incident involving restraints and determining whether staff's actions complied with policy. The FIA has the option to approve the use of force as appropriate, to identify a "teachable moment" and provide specific coaching to the staff involved, or to refer the incident for investigation. Each month, the FIA's assessment and decision-making is reviewed by a Facility Resource Administrator (FRA) from DYS Central Office. Over the past few months, the FRA has identified a number of problems that suggest the FIA review process is not as robust as it should be. First, the FRA has consistently found that the FIA has missed several "teachable moments" in his reviews. These include things like the way a particular MYR technique was executed, the use of the hand-held camera, or the presence and actions of the Supervisors on the scene. The FRA's monthly reports encourage the FIA to be more vigilant about such things and to ensure that he documents the coaching and training delivered to staff (which is the whole point of the review—to help staff develop skills to manage the next incident better). The number of "teachable moments" identified by the FIA increased sharply toward the end of the monitoring period, perhaps in response to this feedback from the FRA. While the fact that the FRA was detecting so many unidentified problems indicated that the FIA review process was not functioning as designed, the multi-layered audit process—all focused around whether staff are being provided with the feedback they need to increase their skills—is a tremendous asset. The State's ability to identify and resolve to its own problems, absent DOJ oversight, is a very important part of their ability to achieve substantial compliance with the Stipulation.
Steps Taken to Assess Compliance	*Staffing* The previous monitoring period identified staffing as one of the major contributors to the facility's difficulty in reaching substantial compliance with the Stipulation. Youth in the general population were denied access to programming, youth on the Progress Unit were spending exorbitant amount of time in their rooms, and the prevalence of youth violence was attributed, in part, to not having sufficient numbers of staff available to

	supervise the youth. When the facility began to hold Involuntary Disability Separation (IDS) hearings in January 2012, the staffing situation began to improve noticeably because positions historically filled by staff who had exhausted their leave benefits became vacant and could be filled by someone who was able to report to work. In 2011, the facility averaged approximately 8 vacant YS positions, but had approximately 40 staff who were not reporting to work because of OIL, FMLA, etc. Throughout 2012, IDS hearings lead to an increase to approximately 20 vacant positions (which could then be filled) and a reduction to approximately 20 staff who were not reporting to work. Obviously, the IDS hearings broke the logjam and have improved the facility's capacity to rectify its staffing problem. In addition, the facility utilized data on its YS turnover rate to justify the need to overhire, which resulted in a net increase in the number of staff. Knowing that the turnover rate among YS staff was approximately 50%, between March and September 2012, the facility hired 41 staff. When balanced against the 21 positions that became vacant via resignation or termination, the facility had 20 new staff remaining, which mitigated the overall number of vacancies. Still, facility and DYS administrators report that the turnover rate at Scioto is the highest across the system and continued efforts are necessary to ensure that sufficient numbers of staff are available. On any given day, approximately 25% of the YS positions are either vacant or occupied by someone who is not reporting to work. While this shortage if offset to some extent by interim staff, even with those additional staff, the facility's staffing levels still come up short. On several days during the previous monitoring period, insufficient numbers of YS reported to work causing several units to be locked down. During the current monitoring period, while the facility continued to require staff to work overtime in order to meet required staffing levels, the levels of staff were sufficient to avoid lockdowns and to provide youth with access to education and other required programming. However, excessive reliance on overtime is neither a practically nor fiscally sustainable strategy for managing the facility. Each month, the Superintendent's Report identifies the number of times a Youth Specialist was required to work overtime in order to meet required minimum staffing levels. As a crude measure of frequency, note that there are approximately 90 shifts in a month (30 days x 3 shifts = 90). The number of times staff were held over varied significantly across the monitoring period (March 77; April 51; May 48; June 19; July 22; August 48; and September 80), with an average of 49 times per month (or, on a little over half of the shifts). Clearly, at some points during the monitoring period, the use of overtime was relatively low, while at other times, overtime was

	needed far more frequently. High overtime months were associated with serious staff assaults and the resulting resignations of staff, along with the beginning of football season, when staff were more likely to call out on the weekends. Continued efforts to ensure that vacancies are kept to a minimum and that staff report to work as expected are absolutely essential to the State's ability to comply with the Stipulation. Without sufficient numbers of well-trained, well-rested staff, the facility will be unable to reduce violence, limit the use of seclusion, and provide adequate programming, as required. Moving forward, the facility intends to continue with its IDS hearings and increase the number of interim staff to reduce the number of days the facility is running short. Further, recent improvements to On-The-Job training were designed to improve job satisfaction and increase retention levels. Finally, in January 2012, the facility intends to combine two of the boys' general population units (accomplished in large part by transferring approximately 15 to 18 boys to other facilities) which will reduce the overall number of staff required on any given day by approximately 12 staff. *Investigations Related to Use of Force, Seclusion and Abusive Practices* Over the past six months, 28 allegations of excessive or inappropriate uses of force were investigated, 6 by the Chief Inspector's Office (CIO) and 22 by a facility-based investigator. Eleven of the facility-based investigations were pending, nearly all of which had far exceeded the 14 days permitted for their completion. Of the 17 investigations that had been completed, two (11%; one CIO, one facility-based) were substantiated for unnecessary or excessive force. Although these 28 referrals flowed from nearly 350 restraints during this time period (rate of allegations is 7%), the poor quality of the investigations completed by facility-based staff creates concern about the extent to which staff who use force improperly can be accurately identified via the investigation process. These concerns are discussed in detail in III.A.5, below, but are relevant to this provision insofar as a poorly constructed investigation does not adequately protect youth from harm at the hands of staff, as required by this provision. In addition to the use of force investigations, the CIO also investigated and sustained 3 allegations of abusive practices: • After an initial refusal to come out of the shower when directed to do so by staff, a youth was left in a locked bathroom overnight; • Several youth were denied dinner and were left in soft restraints overnight; and • A staff member turned off two youth's air vents and water supply over night because they refused to close their cuff ports.

	All of these incidents occurred on the PROGRESS Unit. While it is positive that the incidents were reported, investigated thoroughly, substantiated based on the facts, and staff were held accountable, the fact that staff continue to engage in these types of behaviors, particularly during a time when the PROGRESS Unit has been under such scrutiny, is disturbing. *Allegations of Verbal Mistreatment or Inappropriate Sexual Relationships* Each of the previous Monitor's reports has discussed the problem of allegations of verbal abuse by staff and inappropriate relationships between Scioto staff and youth. The usual tools to combat this type of problem (e.g., staff training, a robust grievance process, and procedures for investigating allegations) have not been sufficient, as youth continue to report inappropriate comments and behaviors by staff to both the Monitors, DOJ attorneys and facility staff. Although the frequency of allegations of a sexual nature has decreased somewhat, more prevalent are reports from youth that staff provoke, antagonize, belittle or otherwise interact in unprofessional, counterproductive and hurtful ways with youth. Indeed, there were approximately 12 new allegations of such behaviors referred for investigation during the current monitoring period (6 related to inappropriate sexual relationships between staff and youth and 6 related to verbal threatening, name-calling, or unprofessional conduct by staff in their interactions with youth). Five allegations of a sexual nature were unsubstantiated by the CIO, although one is still pending. As noted in previous reports and in Provision III.A.5, below, the investigations by the CIO are high-quality, thorough, and certainly capable of sustaining a true allegation if the evidence were available. On the other hand, facility-based investigations were undertaken for the other six allegations, none of which were substantiated. As noted in the discussion of Provision III.A.5, the poor quality of the investigations results in the likely inability to sustain a true allegation, even if the evidence were available. Also troubling is youth's continued belief that neither the grievance process nor the investigation process can protect them because neither will result in staff being held accountable for their behavior. During the site visit week, the vast majority of the youth currently housed at Scioto were interviewed either by Monitors of the *DOJ* case, the Lead Monitor of the *SH* case, or the DOJ attorney. Nearly all of the youth reported concerns about a number of staff who appear to act with impunity, who treat the youth poorly and then taunt the youth to write a grievance because "nothing will happen." When youth gave examples of poor treatment by staff, the interviewers asked if they had reported the incident to anyone at the facility. In some cases they had, in other cases they hadn't, but in all cases their experience suggested to them that it

	would not change the environment for the better. While the Monitor recognizes that youth are not always truthful when interviewed, the similarities in their descriptions of staff's bravado suggest that the facility needs to address the manner in which some staff relate to the youth in their care. During the previous monitoring period, the facility's administrative team committed to implement two new initiatives designed to address allegations of inappropriate sexual relationships in particular, but which could also be useful in addressing the more general complaints about staff verbal mistreatment. The State was asked to provide an update on the status of these initiatives: • Although the previous facility Superintendent indicated that the topic of inappropriate conduct by staff, boundary issues, etc. would be added to the girls' Trauma Group curriculum in April 2012, it was not implemented until August 2012. The 6-week "Healthy Boundaries and Relationships" group was led by a social worker who works for a contracted treatment provider and was co-facilitated by Scioto social workers on the Davey and Allman units. Progress notes from 6 girls who participated in the program were reviewed. The curriculum included an appropriate range of topics (e.g., characteristics of healthy/unhealthy relationships, boundaries, inappropriate relationships due to age or roles, grooming behaviors to encourage girls to acquiesce, etc.). Various homework assignments were given including discussing people with whom they've had boundary issues and the different choices they could have made, or writing a letter to a sibling to describe what was learned in the group. None of the girls in either of the groups raised issues related to inappropriate relationships or conduct by Scioto staff. The group was reportedly well received, with several girls asking to continue the discussion and to incorporate role play so that they could practice the skills they were learning. The facility also plans to incorporate materials available through the NIC/PREA curriculum. A timeline for restarting the group was not provided to the Monitor. • In the last Monitor's report, the Monitor also advised the facility to incorporate the topics of over-familiarization and boundary issues between staff and youth into the weekly Interdisciplinary Treatment (IDT) meetings. The topic was added to the IDT agendas beginning in August 2012 and was broadly defined to include youth who may be touching each other inappropriately and youth who seem to be developing crushes on staff an

	behaving in inappropriate ways. This addition to the agenda reportedly helped staff to be able to address issues with a number of youth and helped staff to discusses what may have otherwise been sensitive topics. New staff were reminded not to be alone with girls in areas where there were no cameras and were instructed to take another youth or staff with them to ensure there was a witness to all of their interactions. Unfortunately, record keeping in this area was substandard and does not provide for a review of the actual interactions that took place during the IDT meetings. The facility has identified improvements in the quality and detail of the IDT minutes as an area in need of development. The "Healthy Relationships and Boundaries" groups have clearly provided new opportunities for youth to think about and discuss any inappropriate relationships they may have had. The Monitor fully supports the continuation of this group, along with any other efforts to fortify the screening and vetting of staff for their appropriateness to work with girls. However, from the discussions with youth, it appears that the problem does not entirely reside in their not having any forum to voice their concerns, but rather in their belief that the facility will not act on their complaints. This was an issue for both the boys and girls housed at Scioto. The facility has indicated its intention to work with the YS union in order to be able to reassign staff who garner a number of complaints from youth. More broadly, emphasizing appropriate communication skills for staff and clear prohibitions against the use of any language that could be construed as taunting, provoking or belittling should become a centerpiece of shift-briefings, staff meetings, training, and any other forum available to reinforce this central value. Finally, improving the quality of the facility-based investigation process may provide the facility with additional opportunities to hold staff accountable in a way that may be persuasive to staff who persist in acting with impunity.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Reach substantial compliance with provisions related to seclusion, investigations of abuse and neglect, grievances and programming. 2. Conduct a problem-solving analysis to determine the nature of youth on staff assaults and implement interventions that target the underlying causes and patterns. 3. Improve the quality of FIA reviews of the use of physical restraint to ensure that staff have exhausted all other means for resolving problems with youth. Ensure that staff are provided with coaching to help develop their skills in this area and to ensure their compliance with all related policies.

	4. Maximize the number of permanent, full-time staff who are recruited, hired and retained so that staff turnover and mandated overtime can be minimized. 5. Continue to provide forums for female youth to discuss their problematic relationships with staff, whether sexually inappropriate, verbally abusive or otherwise unprofessional. Consider developing a similar forum for male youth. Investigate and enforce the prohibition against inappropriate sexual behavior, verbal mistreatment and policies prohibiting male staff from being alone with female youth. Ensure staff know how to recognize, respond to, and report such behavior. 6. Reinforce the prohibition against provoking, taunting, belittling and otherwise disrespecting youth. Investigate complaints vigorously and enforce the conduct standards when they are violated.
Sources of Information	• Self-assessment data and its interpretation for III.A.1, prepared at my request • Interviews with facility Superintendent and Deputies, along with staff from DYS Central Office • Monthly Superintendent's Reports, April through September 2012 • Monitor's Monthly Data, Scioto Male and Female Population, 2011 and 2012, to date • CIO and facility based investigation log, April through September 2012 • CIO and facility-based investigations completed between April and September 2012 • Description and Group Notes from "Healthy Relationships and Boundaries" groups, August through October 2012 • Description of Overfamiliarization Initiative, prepared at my request • Interviews with n=16 youth housed at Scioto on October 19, 2012, and consultation with other Monitors and the DOJ attorney who interviewed approximately 30 other youth housed at the facility in October 2012

III.A.3 Seclusion. The State shall develop and implement policies, procedures and practices so that staff use seclusion only in accordance with policy and in an appropriate manner and so that staff document fully the use and administrative review of any imposition of seclusion, including the placing of youth in their rooms outside normal sleeping hours.	
Compliance Rating	Partial Compliance
Self Assessment	The State presented data on the use of seclusion during the previous six months. The Monitor structured the site visit such that the opportunities for interpreting the trends was more limited than it had been in the past. In addition, the Facility Superintendent had only been in place for approximately two weeks and thus was not in a position to explain the practices of the prior Superintendent nor had he had an opportunity to demonstrate the direction in which he hoped to take the facility with regard to the issue of seclusion. Thus, the Monitor interpreted the trends in regular, pre-hearing and intervention seclusion data without significant input from the State. The Monitor became aware of several quality assurance tools that instill confidence in the State's capacity to make data-driven decisions and to measure the effect of reforms. The State has offered verbal commitments to reform its use of seclusion, the particulars of which are discussed below. Finally, over the past few months, the Monitor has engaged in lengthy conversations with the State, Plaintiff's counsel, and monitoring teams for both this and the *S.H.* case about the implementation of the PROGRESS Unit (PU). These conversations are well-documented elsewhere and will not be repeated here. For its part, the State acknowledged that the amount of in-room time (a.k.a., seclusion) endured by the average PU youth was higher than desired during the current monitoring period and that a complex constellation of staffing, treatment, philosophical and environmental issues needed to be addressed.
Steps Taken to Assess Compliance	*Regular Seclusion* Regular seclusion is a time-out, or short period of isolation imposed by direct care staff in response to mid-level, non-violent misconduct such as throwing things, property damage, storming around the unit, etc. Staff must obtain approval from a supervisor before placing a youth in regular seclusion and again at the one-hour mark. If the youth remains in seclusion at the three-hour mark, the supervisor must document in writing the reason that seclusion remains necessary. As discussed in the 1st Monitors' Report, the facility witnessed a huge spike in the use of regular seclusion just after the facility converted to a long-term facility. Historically, the facility averaged about 70 regular seclusions per month. In August and September 2011, however, the number skyrocketed to approximately 400 and well over 50% of the

seclusions lasted longer than 4 hours. The Second Monitor's Report noted that the use of regular seclusion had returned to historical levels, with an average of 65 seclusions per month (average rate per youth = .43). Across the previous monitoring period, 88% of the seclusions lasted less than 4 hours and 12% lasted more than 4 hours.

As shown in the table below, during the current monitoring period, the number of regular seclusions decreased again to an average of 50 per month; however, because of the declining population, the rate of regular seclusion actually increased to an average of .53 (an increase of approximately 23%). An increase in the use of regular seclusion is not necessarily a bad thing, if the time in seclusion allows the youth to regain control of his behavior and prevents a subsequent act of violence. However, the length of stay in seclusion should be carefully monitored to ensure that staff do not resort to seclusion as a way to avoid working with the youth to resolve the problem.

Compared to the previous monitoring period, the proportion of seclusion episodes lasting more than 4 hours increased. Currently, 19% of regular seclusions last more than 4 hours. The average length of stay varied considerably, between 3 and 13 hours across the six-month period, with an overall average of 7 hours. [The facility attributed these increases to the influx of close custody youth from IRJCF and CJCF.] The shift away from previous trends—where approximately 90% of the youth in regular seclusion were released in less than 4 hours—coupled with an increasing average length of stay—which means that the youth who stay in regular seclusion are there for a significant period of time—is concerning. In July and August 2012, approximately 15-20% of the population had a stay in regular seclusion that lasted well beyond what is customarily considered to be a "cool-off."

Regular Seclusion, April through September 2012

Month	#	Rate (#/ADP)	% 4hrs or less	ALOS (hrs)
April 2012	59	.50	83%	8
May 2012	55	.55	97%	3
June 2012	41	.45	91%	5
July 2012	45	.54	71%	8
Aug 2012	45	.51	60%	13
Sept 2012	56	.65	88%	5

Source: Data prepared by DYS to respond to the Monitor's request for information on the use of seclusion.

Quality assurance audits of the use of regular seclusion need to be conducted to ensure that supervisors are assessing youth for their

readiness for release at the required intervals and that continued time in seclusion is warranted and properly documented. These data should be submitted to the Monitor for review over the next monitoring period.

Pre-Hearing Seclusion

Pre-Hearing Seclusion (PHS) is a period of isolation imposed following an act of violence (AOV), pending a disciplinary hearing. Youth on PHS remain in their rooms except for showers. Youth are supposed to receive recreation and Unit Instruction (i.e., education) outside of their rooms, but as discussed in the Special Education section of this report, this has not yet been accomplished. The length of time a youth remains on PHS is primarily determined by his or her IRAV score, which is based on the severity of the current rule violation and the youth's history of non-compliant behavior.

The rate of PHS generally tracks increases and decreases in the rate of AOV and does not give much insight into the facility's seclusion practices. Rather, it is changes in the youth's lengths of stay that reflect whether practices around the use of PHS are being reformed as required by this Provision. During the previous monitoring period, the time spent in PHS was relatively stable across the months, with 67% remaining in PHS for more than 24 hours.

Throughout the current monitoring period, an increasing proportion of youth spent at least 24 hours on PHS. During the last 4 months of the monitoring period, nearly all youth spent over 24 hours in PHS. The average length of stay (ALOS) in PHS also increased throughout the monitoring period. Across the 6-month period, the average youth spent over two days in PHS (53 hours). These patterns remain when the length of stay is viewed within the IRAV risk groups. In other words, both high risk (A level) and moderate risk (B level) youth's ALOS increased throughout the monitoring period. [There were too few low risk (C-level) youth for meaningful analysis.]

Pre-Hearing Seclusion, April through September 2012

Month	#	Rate (#/ADP)	% 24+ hours	ALOS (hrs)
April 2012	48	.41	73%	54
May 2012	32	.32	75%	37
June 2012	27	.30	89%	45
July 2012	49	.59	90%	54
Aug 2012	46	.52	88%	61
Sept 2012	26	.30	96%	67

Source: Data prepared by DYS to respond to the Monitor's request for information on the use of seclusion.

	In addition to the trend data discussed above, the State also provided disaggregated data that better illustrate the problems in this area. Spreadsheets tracking each individual act of violence (AOV) reveal that in July 2012, most youth spent well over two days in PHS, although the individual lengths of stay varied and thus appeared to be individually derived. However, in August and September 2012, nearly all of the PHS episodes lasted the maximum of 72 hours. The purpose of PHS is to ensure allow the youth sufficient time to regain control of his behavior and for staff to talk to the youth to understand what occurred and whether a risk of subsequent violence (i.e., retaliation) exists. PHS should not be used as a punishment—however, given the uniformity in duration across youth and the fact that nearly all youth are held to the maximum allowable time, it appears that the facility has been using PHS punitively. The trends witnessed in the previous monitoring period—of a decreasing length of stay on PHS for youth at all IRAV levels—have apparently reversed. Although the Monitor supports the use of structured decision-making tools in general, it appears that IRAV has gone too far in removing staff discretion in determining a youth's readiness for release. Rather than making a considered assessment of the youth's current behavior and readiness to safely return to the general population, IRAV seems to have resulted in staff's leaning toward the top end of the ranges prescribed by IRAV. Revisions to the IRAV lengths of stay ranges were pilot tested at CJCF during the current monitoring period. Discussions with the *S.H.* subject matter expert overseeing these reforms indicated that the significant reductions in the lengths of stay for each IRAV category were accomplished without an escalation of violence at the facility. These data are compelling and suggest that the IRAV is ripe for further modification. While on site, the Monitor discussed ideas for reforming IRAV with DYS administrators. A tempered approach to this reform is absolutely necessary in order to create buy-in among staff (who could be persuaded by showing that incremental reductions in the duration of PHS do not result in more youth violence, as shown by the Circleville IRAV pilot) and to constrain the extent to which youth attempt to "test the limits" of the new procedures. The Monitor recommends that, as an initial first step, the DYS maintain the minimum thresholds being proposed by the *SH* monitor for each risk level, but that, thereafter, a youth's readiness for release is evaluated at 3-hour intervals. This assessment must include a broad range of indicators (e.g., youth's willingness to discuss the issue with staff, mediate the issue with the youth/staff involved, undertake some sort of restorative activity, etc.), but should NOT be based on the staff's disapproval of the youth's original rule violation. PHS is not about punishment—it is about protecting other youth and staff from subsequent violence from the youth involved. Retribution should not be a part of the length of stay calculation. At each three-hour interval, if the

	Supervisor determines that the youth cannot be returned safely to the general population, the specific reasons for this decision must be articulated in writing. Conversations with DYS and the *S.H.* subject matter expert during the review phase of this report resulted in a broad consensus about the next phase of revisions to the IRAV. The Monitor approved the policy revision on December 24, 2012. Changes in the length of stay in PHS will be tracked throughout the next monitoring period. Hopefully, the policy revision will produce the intended reductions and outcome data will lay the foundation for additional reductions in the minimum length of stay for A-level youth. At Scioto, the duration of PHS does not appear to be at all related to the length of time required to prepare for the Intervention Hearing (IH), which is how many jurisdictions anchor the "top end" of PHS (i.e., the youth is held in PHS until the hearing, which must occur within a designated period of time). While facility administrators reported that the IH "should" occur within 72 hours, the disaggregated AOV data indicate that it rarely does. The IH was usually held 7-10 <u>after</u> the incident occurred. The delay between the incident and the procedure employed to hold youth accountable severely compromises the effectiveness of the sanctions imposed. [Sanctions are more effective when they are imposed soon after the behavior of concern]. The IH officer needs some time to ensure that the incident is investigated thoroughly and the youth must be provided notice of the proceedings and have an opportunity to prepare his or her defense. However, requiring staff to hold these proceedings sooner rather than later is certainly in the interest of justice (because it would remove the claim that the youth is serving the punishment in the form of PHS, before the hearing is held), would afford greater protection from the risk of self-harm (a significant proportion of successful suicides in juvenile correctional facilities occur among youth who are in some form of disciplinary seclusion), and would speed the process for actually addressing the underlying causes of the youth's behavior through the consequences that are selected by the hearing officer or IDT. During the review period for this report, DYS shared plans for an upcoming policy revision (Policy # 303.01.03 "Youth Intervention Hearings"). When the new policy takes effect (projected for February 2013), the timeline for IH hearings will be 7 days. While this is an improvement, the Monitor encourages DYS to continue efforts to hold hearings in closer proximity to the incident for which the youth is being sanctioned. *<u>Intervention Seclusion</u>* Intervention hearings are held to determine whether youth are culpable for serious misconduct and whether additional time in seclusion is warranted. While on Intervention Seclusion, youth remain in their rooms except for showers. Youth should receive recreation and Unit Instruction

(i.e., education) out of their rooms, but anecdotal reports from youth suggest that they do not. By policy, youth can receive a maximum of 5 days of Intervention Seclusion, but the policy also allows for the use of alternative sanctions to respond to primary rule violation. Recently, a some of the major rule violations are being handled by the IDT, which is a promising practice given that treatment teams tend to design sanctions that are more responsive to the underlying causes of the youth's behavior. In contrast, seclusion serves only to suppress a youth's negative behavior during the time that he or she is behind a locked door and also denies youth access to the very treatment programs they need in order to change their behavior.

The previous Monitor's report discussed the significant decreases in the use of Intervention Seclusion, due in part to an overall reduction in AOVs and also to the former Superintendent's commitment to use alternative sanctions more frequently. Evidence of the more limited use of seclusion as a sanction continued into the beginning of the monitoring period, but then the use of intervention seclusion increased sharply. The total IS hours imposed increased, as did the number of hours per youth (which is calculated only to neutralize changes in the number of youth involved in AOV. Since some youth do not receive any seclusion time, the actual number of hours in seclusion for those who received it is longer than the average number would indicate.)

Intervention Seclusion Hours, April through September 2012			
Month	# Y involved in AOV	Total IS hours	Hours per Youth
April 2012	46	76	1.65
May 2012	40	159	3.98
June 2012	29	24	0.83
July 2012	34	186	5.47
Aug 2012	30	163	5.43
Sept 2012	29	899	31.00
Source: Monthly Superintendent's Report, which counts the number of youth involved in AOV (not AOV incidents) and the total number of IS hours			

Other data submitted by the State (AOV spreadsheets) revealed that the proportion of Intervention Hearings that utilized seclusion as a sanction also increased throughout the monitoring period. In July 2012, only 3% of the IH resulted in seclusion, compared to August and September 2012 when 40% and 79% of IHs resulted in the use of seclusion as a sanction.

These increases are concerning and their underlying causes are

	undoubtedly complex, including but by no means limited to a combination of the facility's leadership's philosophy, the severity of the AOV, and the alternative sanctions available. As discussed in previous reports, not only is seclusion one of the least effective tools for managing youth behavior, it also decreases youth's access to needed treatment programs and increases frustration and anger and thus elevates their risk of self-harm. The recent assignment of the IDT to handle certain rule violations is certainly positive. IDTs can pull on the resources of their multi-disciplinary members to construct sanctions that are balanced between treatment and supervision, and provide an ideal opportunity for direct care staff to engage in the important work of supporting the skill development that takes place in treatment. However, IDTs should be cautioned not to order sanctions of questionable value (e.g., rote writing assignments, "sitting on the door" for days on end without adjunct treatment work, community service work or other restorative activity). While the Monitor did not have aggregate data regarding the types of sanctions the IDTs imposed, anecdotes from youth suggested that at times, the sanctions imposed were of questionable value. The AOV spreadsheets identify the proportion of AOVs that were handled by the IDT rather than the IH process. The IDTs handled fewer cases toward the end of the monitoring period—in July 30% of AOVs were handled by the IDT, compared to only 22% in August and 12% in September 2012. The reasons for this decline are unknown. The State did not offer any quality assurance data related to this function of the IDT meetings and, if it has not already done so, should develop performance measures that are regularly assessed to determine whether this process has been implemented as intended (e.g., types of sanctions that are imposed) and whether the intended outcomes are being achieved (e.g., youth's subsequent involvement in violent misconduct). A new sanctions grid will be rolled out in February 2013 and DYS should be conscientious about collecting data to assess the impact of the changes. The new grid reduces the amount of intervention seclusion time and intervention time that may be added to youth's sentences. These changes are very positive, but good data are needed to demonstrate to the various constituents that sanctions conform to the new prescriptions and that they were accomplished without compromising the safety and security of the facility. *Seclusion among Youth on the Progress Units (PU)* The Monitor has voiced serious concerns about the operation of the PU since its inception at Scioto in September 2011. The Parties and Monitoring Team members have had multiple conversations about the term "seclusion" and whether it applied to the in-room time on the PU.

	Until the new schedule was implemented on October 15, 2012 (discussed below), youth on the PU spent nearly all of their waking hours in their rooms. This in-room time was not a sanction for a proximate disciplinary offense (like the seclusion discussed above), but was imposed only by virtue of their being housed on the PU as a result of their history of misconduct and the State's failure to schedule programming throughout the day for these youth. The Monitor inadvertently implied that this in-room time was part of the PU treatment program by calling it "Programmatic Seclusion" in previous Monitor's Reports. This label was selected ***only*** to differentiate these in-room hours from those endured by youth as an immediate consequence for an AOV and was not intended to imply that in-room time was an acceptable component of the PU program design. In fact, a label was applied in order to stress the importance of eradicating the practice. Protracted arguments about the label that should be applied appeared to steer conversation away from the fact that a program intended to treat and manage the system's most violent youth ***cannot*** rely on the use of in-room time to the extent that the PU has since its inception. Youth on these units should be engaged in meaningful treatment, education and programming throughout their waking hours (as required by Provision III.F.1, below). Extensive time in their rooms will only lead to frustration and anger, which most of these youth will express in the form of violence—the very behavior that the PU purports to want to minimize. The extent to which PU youth were actually engaged in programming during the current monitoring period is discussed in III.F.1, below. Only recently (just after the current monitoring period ended) were tangible changes made to the program design to try to reduce the extreme over-reliance on in-room time to manage youth's behavior. In addition to increasing the staffing of all types (education, direct care, mental health, recreation and Supervisors) on the unit, a 24-hour schedule in which all PU youth are out of their rooms during waking hours in the same measure as youth from the general population was implemented on October 15, 2012. The key performance measures must be tracked on an individual level over a sustained period of time (e.g., in-room time for each youth, over a 90-day period) in order to develop even a preliminary finding that the schedule has been properly implemented. At this point, the schedule is far too new to make any conclusions about whether it has resolved the extreme overreliance on seclusion that has characterized the PU since its inception. Other planned modifications to the PU program design should be implemented to further reduce the amount of time that PU youth spend on intervention seclusion (in addition to the system-wide reforms to IRAV discussed above). These include improvements in treatment planning, measuring youth's progress toward tangible goals and

	procedures for re-examining the treatment approach with youth who are not progressing as planned. The details for these modifications have not yet been finalized, nor has a quality assurance process to ensure that key outcomes (e.g., decreased involvement in violent misconduct, shortened length of stay on each Phase, shortened overall stay on PU) are being achieved.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Identify and address the underlying causes of recent increases in the length of stay in regular seclusion. 2. Modify the IRAV to ensure that youth remain in pre-hearing seclusion no longer than necessary to de-escalate their behavior and ensure they do not pose a threat to the safety of other youth or staff. Consider adjusting the requirements surrounding the timing of Intervention Hearings to improve the effectiveness of the sanctioning process. 3. Limit the use of intervention seclusion, relying instead on sanctions that provide an opportunity for skill development and treatment in order to create behavior change, and collect data to demonstrate the extent to which this change has occurred. Develop quality assurance mechanisms around the use of seclusion in Intervention Hearings and to determine whether the recently implemented IDT sanctioning process is a viable strategy for reducing the reliance on intervention seclusion. 4. Ensure that youth on the PROGRESS Unit are not scheduled to be in their rooms in any greater measure than youth in the general population. Ensure their daily access to a full range of education, treatment, recreation and structured programming. 5. Ensure that the PROGRESS Unit's program design (e.g., staffing, treatment, programming, etc.) is sufficient to reduce youth's involvement in violent misconduct so that the use of pre-hearing and intervention seclusion is limited.
Sources of Information	• Self-assessment data for III.A.3, prepared at my request • Monthly Superintendent's Reports, April through September 2012 • Consultation with Steve Martin, subject matter expert for *S.H. v. The State of Ohio*, regarding modifications to IRAV • On-going discussions with the Parties regarding the design and operation of the PROGRESS Unit

III.A.5 Investigation of Serious Incidents. The State shall develop and implement policies, procedures and practices so that appropriate investigations are conducted of all incidents of: use of force; staff-on-youth violence; serious youth-on-youth violence; inappropriate relationships with youth; sexual misconduct between youth; and abusive institutional practices. Investigations shall be conducted by persons who do not have direct or immediate indirect responsibility for the employee being investigated.	
Compliance Rating	Partial Compliance
Self Assessment	The State submitted a log of all investigations related to excessive uses of force, allegations of abuse, allegations of verbal abuse, and inappropriate relationships completed during the current monitoring period. The Chief Inspector's Office (CIO) investigated the more serious allegations, while facility-based investigators addressed the less serious allegations. Between April 2012 and September 2012, a total of 32 investigations were completed related to the topics covered by this provision (17 of these were completed by facility-based investigators and 15 were completed by the CIO). Only 1 of the 17 facility-based investigations (6%) was substantiated (unnecessary use of force). This represents a generally declining trend in the proportion of investigations that are substantiated (1st Monitors' Report reported 39%; 2nd Monitors' Report reported 10%). As noted in the previous Monitors' report, the low proportion of substantiated allegations is likely due to the poor quality of the facility-based investigatory process. Five the 15 CIO investigations (33%) resulted in a substantiated finding. Staff were cited for: • Inappropriate contact with a youth after she was released; • Unnecessary use of force; • Leaving a youth locked in a shower/bathroom overnight; • Denying several youth dinner and leaving them in soft-restraints overnight; and • Turning off the air vents and water flow to two youth's rooms. As discussed in the next section, in contrast to the facility-based investigations, the CIO investigations are generally of high quality. Historically, the CIO has conducted quarterly audits of the facility's investigations and provided detailed technical assistance in its written reports. The most recent CIO report covered Q1 2012 (prior to the beginning of the current monitoring period) although the report was issued in July 2012. The Q1 report focused exclusively on the AMS incident reporting procedures and not on the process or quality of the facility-based investigations. However, recent technical assistance and training has been provided to the Labor Relations Officer (who is tasked with assigning and tracking the investigations) and the Deputy Superintendents who are responsible for reviewing and approving the

	quality of the investigations. Given the findings detailed below, additional training for investigators is sorely needed. Moving forward, the CIO plans to shift its monitoring strategy so that each DYS facility will be monitored every 4 months. This shift will permit a more rigorous review and more timely reports, since the facilities will now be audited one at a time.
Steps Taken to Assess Compliance	*Investigations Conducted by the Chief Inspectors Office (CIO)* Timeliness. Of the 15 investigations reviewed, 10 (66%) were completed within the timelines prescribed by policy (i.e., 14 business days for use of force investigations; 30 calendar days for all others) or were granted an extension for cause (e.g., key witness was unavailable; delay in obtaining permission to proceed from the OSHP). The remaining 5 investigations (36%) were submitted beyond the timelines permitted by policy but had not been granted an extension (average number of days late = 6). While the goal of producing a high-quality investigation is paramount, investigators must either complete investigations within the prescribed timelines or should obtain an extension, even when only a few extra days are needed. Occasional timeline violations are unavoidable, but the current rate of timeliness (66%) is simply not sufficient. At the time of the Monitor's site visit, the CIO also had 8 pending investigations, 3 of which had not yet reached their due dates and the other 5 had legitimate reasons for an extension (e.g., suspect was in jail; awaiting DNA evidence; key witness had been in car accident). Quality. Each of the 15 CIO investigations completed during the Monitoring period was reviewed. As in the past, the investigations were very well done. They featured comprehensive interviews with all key witnesses, utilized videotaped footage effectively, and pursued tangential issues that emerged during the course of the initial inquiry. Across the sample, the findings appeared to be reasonable and the basis for the conclusions was clearly identified among the evidence. *Investigations Conducted by Scioto Staff* Timeliness. Of the 17 investigations conducted by Scioto staff during the current monitoring period, only 4 (23%) were completed within the timelines prescribed by policy. The remaining 13 (77%) were late (an average of 18 business days), which is a significant increase from the previous monitoring period where 42% were late. In addition, at the time of the Monitor's site visit, 11 facility-based investigations were pending and overdue (average days overdue was 57). Two other pending cases had not yet reach their due dates. The State reported that it was aware of these problems and had recently made

	changes to the assignment, oversight and review process in an effort to correct these deficiencies. Timely investigations are essential for a robust process to address allegations of employee misconduct. Should the allegation be substantiated, staff training or discipline needs to occur as soon as possible so the individual can either return to duty, be retrained, or be terminated, as appropriate. If the allegation is not substantiated, the employee needs to be cleared so that he or she may return to full duty and be relieved of the stress and stigma of being "under investigation." Quality. The previous Monitor's report downgraded the compliance rating for this provision to Partial Compliance upon finding that the quality of the investigations conducted by Scioto staff had sunk far below professional standards. Unfortunately, the quality of the investigations has not improved at all. As in the previous monitoring period, the Monitor provided detailed feedback on each of the 17 cases to develop consensus around the essential elements of a quality investigation and to highlight the many features that were lacking from the most recent set of investigations. To summarize: • Allegation statements need to be specific (who is alleged to have done what to whom, and when?) in order to set the context for the subsequent information. Too often, key facts were missing and it was not until several pages into the investigation that the nature of the allegation could be understood. • Any delays in assigning or initiating the investigation need to be explained. Long delays in initiating investigations were noted, and were unexplained. In part, the situation could be clarified if the investigator explained how and when the facility became aware of the allegation (which would account for those situations when the youth did not report the concern immediately after it happened). • Everyone who can contribute to the understanding of what occurred should be interviewed. In several cases, the investigator identified a very limited set of witnesses (e.g., the accused staff, the victim and possibly one other staff witness) even though other people were in the vicinity when the incident allegedly occurred. None of the investigations reviewed included a single youth witness interview. • Witnesses should be asked to describe what happened in their own words, and the investigator should seek clarification or additional detail through appropriate follow-up questions. Many times, it appeared that the witness was simply asked to respond to a set of yes/no questions. Without providing an actual transcript, the full exchange between the investigator and the

	witness needs to be captured in the interview summary. • The sequence of the interviews is important. The alleged victim should be interviewed first in order to obtain a complete accounting of the youth's concerns and to obtain details that can be used to construct questions with the witnesses and the accused staff. The accused staff should be interviewed last, so that he or she can be asked to respond to the specific allegations discovered during the previous interviews. In several cases, the accused staff was interviewed first, and thus the interview did not reflect the variety of issues raised in subsequent interviews. • The basis for the conclusions must be clearly articulated and must rest upon facts that were gathered during the investigation. Many of the investigators do not write coherent narratives and do not summarize the facts that supported the conclusion, and did not explain why they discounted facts that didn't fit. It is worth noting that this is the exact same list of problems articulated in the previous Monitors' Report. It appears that the State has made no progress whatsoever in improving the quality of this essential function. The primary contributor to this problem appears to be the continued practice of distributing the investigations across a large number of staff (16 different people completed the 17 investigations reviewed). Dispersing the responsibility so broadly will inevitably lead to inconsistency, and because each staff person may only do one or two investigations per year, their opportunities to develop the appropriate skill set are very limited. In order to accelerate the State's progress toward compliance with this provision, the Monitor strongly recommends that the State significantly reduce the number of people who are authorized to conduct an internal investigation and that this responsibility is assigned only to individuals who have demonstrated that they have the requisite skill set. Of great concern is the fact that several investigations were assigned to staff who have not attended the investigators' training. The poor quality of these reports cannot continue. Although the allegations investigated at the facility-level are generally less serious, the nature of the allegations are at the heart of the facility's staff culture that has been labeled as problematic by past administrations and that was the chief complaint among the youth interviewed during the current monitoring period. Youth often described staff behaving with impunity, boasting that "nothing will happen" if the youth filed a compliant. The lack of accountability brought to bear by the shoddy internal investigation process is a major contributing factor to this problem.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Reduce the number of individuals authorized to conduct facility-

	based investigations and ensure that these individuals have the requisite skills for the task. Ensure that producing timely, high-quality investigations is a specific job responsibility and that employees are held accountable for their failure to produce reports that meet professional standards. 2. Produce high-quality investigations of all allegations of inappropriate conduct by staff. Whether completed by the CIO or by a facility-based investigator, the investigations must reflect timely, comprehensive interviews with all key witnesses and must arrive at reasonable conclusions based on the facts in evidence. Enact accountability measures to address poor performance by staff tasked with the responsibility to investigated allegations of all types.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.5, prepared at my request • CIO's 2012 Q1 "AMS Incident Report & Investigation Coaching Review," July 2012 • Log, "Investigation Tracking Log, April through September 2012" • Log, "Investigation Tracking Log—PENDING, April through September 2012" • Email communication with J. Fears, CIO, related to CIO cases pending as of October 31, 2012 • "List of staff currently authorized and trained to conduct facility-based investigations," prepared at my request • Review of 15 CIO investigations completed since April 2012 (100% of total) • Review of 17 investigations conducted by Scioto staff since April 2012 (100% of total)

III.D.1 Grievances. The State shall develop and implement policies, procedures and practices to ensure that the facility has an adequate grievance system including: no formal or informal preconditions to the completion and submission of a grievance; review of grievances by the Chief Inspector; timely initiation and resolution of grievances; appropriate corrective action; and written notification provided to the youth of the final resolution of the grievance.	
Compliance Rating	Partial Compliance
Self Assessment	At the time of the previous Monitor's Report, the grievance process at Scioto was experiencing difficulties due to staffing instability and staff performance issues. In May 2012, a new Grievance Coordinator was hired, followed by a back-up Coordinator in July 2012, and these problems have largely been resolved. The CIO conducts quarterly audits of the grievance process at Scioto. The 2012 Q1 report was published in May 2012 and details the variety of problems with the grievance process discussed in the previous Monitor's report. The 2012 Q2 and Q3 reports were published in July and October 2012, respectively. These reports showed that the number of grievances submitted has been unstable (Q1 = 105; Q2 = 201; Q3 = 74) and accurately notes that there is no "correct" number of grievances. Rather, the underlying causes of trends should be examined to determine whether youth simply have more/fewer complaints or whether they access to or belief in the system has been somehow compromised. Fortunately, the various performance measures improved significantly from those reported in the previous Monitor's report. With regard to timeliness, compared to Q1 when 61% were resolved past the 14-day timeline permitted by policy, only 23% of grievances were overdue in Q2 and only 3% were overdue in Q3. With regard to the quality of resolution, the proportion of grievances requiring follow-up documentation has decreased steadily from 62% (Q1) to 49% (Q2) to 39% (Q3). The improvements were attributed to the significant support received from the DYS Central Office at the beginning of the monitoring period and the arrival of the new Grievance Coordinator at the end of May 2012. The youth's chief concerns discussed in the 2012 Q2 report included complaints about staff's decisions (25% of the 201 grievances submitted), medical care (11%), verbal abuse by staff (8%) and the behavior management system (7%). In Q3, the top complaints were about staff decisions (18%), medical care (11%), food (10%), living conditions (10%) and education (10%). These have remained relatively stable over time. The CIO's quarterly review process continues to satisfy the Monitor's requirement for the State to demonstrate an internal ability to identify and address its problems related to grievances. The CIO has recently shifted its monitoring schedule to ensure that reports are issued more

	quickly. Scioto will be monitored on a rotating schedule every 4 months so that the CIO auditors are completing only one audit at a time, rather than trying to complete quarterly audits for all four DYS facilities every quarter. This shift in the monitoring schedule appears to be prudent so that facility staff can become aware of and address any deficiencies more quickly.
Steps Taken to Assess Compliance	In addition to an obvious commitment to addressing youth's grievances by mobilizing the resources available at the facility, the Grievance Coordinator also has a refreshing commitment to teach youth how to resolve their own problems (e.g., how to access the sick call mechanism) and to reinforce the skills they learn in group therapy related to asking for assistance and making requests in an appropriate manner. *Quality of Resolution* As discussed in the previous section, the quality of the resolution has steadily improved. It is important to understand that the "Follow Up Needed" status in AMS is dynamic. When the problems is cured, the AMS status is changed to "Completed," which means that it is difficult to obtain a running total of the proportion that required additional information in a given time period. However, point-in-time snapshots are useful toward this end. At the Monitor's request, the State produced a list of the cases needing follow up action as of October 11, 2012. In contrast to the Q2 CIO report where 98 cases required follow up, only 16 cases needed additional information in order to be considered "Complete" by the CIO. Of these, 50% (8 cases) were grievances submitted prior to the current Grievance Coordinator's tenure at the facility. During an interview with the Monitor, he discussed his on-going efforts to clear the backlog of problems that he inherited when he assumed the position. That he has reduced the number still in need of attention to only 8 is commendable. As for the other 8, all of them were submitted in September 2012. The absence of any cases submitted in June, July or August testifies to the Grievance Coordinator's commitment to address and rectify problems that are identified by the CIO. This is precisely the purpose and anticipated outcome of the CIO review process. Feedback on the 8 cases from September included reminders to scan documentation into AMS, suggestions to strengthen the quality of the response, and notification about applicable policy (e.g., if a youth indicates a safety concern, he should have a Safety Plan). The input appears to be the type of on-going coaching required by all new staff. Two other grievances were classified as "Corrective Action Needed," referring to the Grievance Coordinator's need for additional instruction around referring incidents for investigation. The Grievance Coordinator does not appear to need an excessive amount of coaching and the types of things for which he receives guidance are reasonable.

Thus, the new grievance coordinator appears to have resolved all of the issues with timeliness and quality of response that were of concern in the previous Monitor's Report.

Youth Survey

As discussed in the previous Monitor's Report, the CIO's 2011 Youth Survey found significant numbers of youth who reported that staff told them that they could not use the grievance process to report staff misconduct (17%), that staff treated them badly after filing a grievance (20%), or that staff told them nothing would happen if they filed a grievance (53%). The CIO required each facility Superintendent to construct a plan to address these concerns. The Scioto plan has not yet been developed. The new Superintendent has been tasked with doing so before the end of the year. The CIO plans to conduct a follow-up Youth Survey at the end of 2012. If the Scioto plan is not implemented soon, it is unlikely that the facility will see any improvement in this area.

Notification to Youth about the Outcome of Investigations

Grievances involving verbal or physical abuse or serious policy violations are usually referred for investigation by the facility or by the CIO. However, if a youth makes an allegation of verbal abuse and the initial contact by the Grievance Coordinator indicates that no witnesses were present, the grievance may be closed without referral. While it is true that an investigation of a verbal exchange with no witnesses is unlikely to be productive, the Monitor recommends that the employee's supervisor be notified of the allegation, in case a pattern should emerge (e.g., problems between the same individuals, or allegations containing the same unique language, gestures, etc.)

In March 2012, the Grievance Policy (# 304.03) was revised to include written notification to the youth of the outcome of investigations that were triggered by a youth's grievance. A letter to the youth from the facility's Labor Relations Officer (LRO) refers to the investigation number and indicates whether the allegation was substantiated or unsubstantiated. The Investigation Policy (#101.15) and the Youth Handbook were also updated to reflect this change in procedure.

During the current monitoring period, a total of 11 grievances were referred for investigation. Youth's allegations included not being permitted to use the toilet, staff's use of threatening language, staff's teasing the youth, being denied food, and excessive time in restraints. Across the 11 cases, two investigations are still pending and the location of two youth who were released is still trying to be discerned. Letters to youth notifying them of the outcome of the investigation were presented

	to the remaining 7 youth (100%). Youth signed the letters to acknowledge their receipt of the information. Although letters were sent out in every case, many of the cases had a significant delay between the date the investigation was completed and the day the letter was drafted. The number of business days from investigation completion to letter drafting ranged from 2 to 29, with an average of 15 business days. Perhaps coincidentally, letters were drafted in 3 of the 7 cases on the day the Monitor requested the documents. These cases had delays of 6, 17 and 21 business days. Thus, youth are being notified of the outcome of the investigations, but the notification needs to be far more timely in order to meet the spirit of the requirement and to address youth's persistent belief that staff are not held accountable for their behavior in any meaningful way. Prompt notification could help to counteract this belief.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Promptly notify youth of the outcome of any investigation referred via the grievance process.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.1, prepared at my request • 2012 Q2 and Q3 Grievance Audits completed by the Chief Inspector's Office • 2012 Q3 Grievance data, prepared at the request of the Monitor • Grievance Monthly Reports, April through September 2012 • AMS Grievance Summary for grievances submitted April through September 2012 • List of grievances referred for investigation, April through September 2012 • Copies of Youth notification letters for grievances referred for investigation, April through September 2012

III.D.2 Grievances Explained to Youth. A clear explanation of the grievance process shall be provided to each youth upon admission to the facilities during orientation and to their parents or guardians, and the youth's understanding of the process shall be at least verbally verified.	
Compliance Rating	Substantial Compliance
Self Assessment	The Orientation process includes two videos—one is a general Orientation video covering several topics including Youth Rights and the purpose of the grievance system. A second video focuses on the grievance process and includes information about what to do if the youth has a problem with living conditions, medical care, staff treatment, education services, etc. The video describes the differing roles of the Grievance Coordinator, the Chief Inspector's Office, and the Legal Assistance Program attorneys. Finally, youth are provided step-by-step instructions for navigating the grievance system. The information in the video is reinforced by a written Youth Grievance Handbook, which an intake staff member discusses with the youth. Youth are also provided in-depth information about sexual abuse and sexual assault in the correctional setting, and how to handle situations in which they may feel threatened or that the staff is being inappropriate. The CIO is also developing a formal Lesson Plan for each DYS facility's orientation in order to ensure that consistent, accurate information is delivered to all DYS youth. The Lesson Plans are scheduled to be rolled out in Q4 2012. All youth are required to sign several forms indicating that they received and understand information about the grievance process. The facility audits a random sample of admissions files every month to ensure compliance with policy and procedure. Each month, April through September 2012, 100% of the youth sampled (30 total youth; 10% of all admissions) received a complete orientation to the facility, which included information on how to access the grievance system. Signed Orientation Acknowledgement Forms were submitted for the Monitor's verification.
Steps Taken to Assess Compliance	At the end of the previous monitoring period, the facility's veteran Grievance Coordinator retired and a new Coordinator had been hired. This staff eventually moved on and the facility had to rely on support from Central Office to keep the grievance process limping along. At the end of May 2012, a new Grievance Coordinator was hired. Upon arriving at Scioto, the Grievance Coordinator began attending UM meetings and unit community meetings to explain the grievance process, his expectations for both youth and staff, and to answer questions. The Coordinator makes himself available to all youth and staff to mediate disputes or respond to crises. The Monitor interviewed 15 youth while on-site. Although all of them

	understood the grievance process and how to use it, over half of them appeared to lack confidence in the system, believing it was "fixed" or otherwise not capable of addressing their needs. Oddly, approximately half of these same youth had accessed the grievance system and reported that the issue was resolved to their satisfaction. As noted in the previous provision, the facility is required by the CIO to plan an initiative to bolster the standing of the grievance process, which may improve its reputation among the youth.
Recommendations	The State is in substantial compliance with this provision.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.2, prepared at my request • Interview with the Grievance Coordinator • Interviews with 15 youth housed at Scioto on October 19, 2012

III.F.1 Structured Programming. The State shall provide adequate structured rehabilitative services, including an appropriate mix of physical, recreational or leisure activities during non-school hours and days. The State shall develop and implement structured programming from the end of the school day until youth go to bed, and on weekends. For youth housed in closed-cell environments, programming shall be designed to ensure that youth are not confined in locked cells except: a) from after programming to wake up; b) as necessary where youth pose an immediate risk of harm to self or others; c) following an adequate disciplinary hearing, pursuant to an appropriate disciplinary sanctions. The programming shall be designed to modify behaviors, provide rehabilitation to the types of youth committed at the facility, address general health and mental health needs, and be coordinated with the youth's individual behavioral and treatment plans. The State shall use teachers, school administrators, correctional officers, caseworkers, school counselors, cottage staff, and any other qualified assistance to develop and implement structured programming. The State shall provide youth with access to programming activities that are required for parole eligibility.	
Compliance Rating	Partial Compliance
Self Assessment	*Structured Programming* The facility offers multiple types of programs that can be tracked using multiple databases: • All youth who have not graduated from High School or obtained a GED are required to attend 330 minutes of instruction per day. Their attendance is tracked using the Chancery database. • All youth should receive one-hour of large muscle activity (recreation) per day. The Unit Managers are responsible for ensuring that recreation is delivered each day by the General Activity Therapists (GAT). Disruptions to the recreation schedule should be logged in the Unit Log. • All youth attend some combination of group and individual therapy, depending upon their needs. The Social Workers and Psychologists, using the CaseNotes database, track youth's participation in these groups. • Youth also have the opportunity to attend religious services, programs delivered by volunteers and activities earned through the SBBMS. IRJCF is currently piloting a database to track youth's participation in these activities and Scioto is planning to adopt this database in the near future. *Strength-Based Behavior Management System (SBBMS)* The facility provided an update on the on-going efforts to ensure that the SBBMS is properly implemented. Reportedly, youth continue to receive privileges that they have not earned, which dampens their motivation to conduct themselves in a manner that would allow them to promote phases. UMs continue to coach the YSs assigned to their units, many of whom are new, on how to use the SBBMS effectively. In addition,

	videogames were moved off the unit into a game room to ensure that youth who have not earned the privilege cannot play them without permission. Further, the OM often makes rounds at bedtime to ensure that YSs are not allowing youth to stay up past their prescribed bedtimes. These modifications indicate that the facility administration remains vigilant to the various ways in which the SBBMS can be circumvented and then develops solutions to ensure that the program is implemented with fidelity. *Programming for Graduates* During the current monitoring period, the facility made significant progress in developing programming for youth who have graduated from high school or obtained their GED. Graduates are now occupied throughout the day in a combination of post-secondary education and employment. • The primary academic program is delivered by Ashland College, which provides coursework for students in English 101, Basic Financial Literacy, Entrepreneurship (Fall) and Problem Solving and Life Skills (Summer). Classes are held twice per week for 4.5 hours. (Classes were held three times per week during the May-August grading period). On the "off days," study hall is held. • An additional academic program is delivered by Henkles & McCoy. TechBridges/Employability Skills is an intensive one-week class, held from 8a to 4:30p each day and offered once per grading period. Youth learn how to disassemble and rebuild computers, and also learn essential employability skills to prepare them for release. Upon release, students are connected to Henkels & McCoy's community facility where they may continue the academic instruction and also receive assistance with job preparation and interview skills. • The Youth Work Program was designed to provide jobs for graduates. [Note: non-graduates may still obtain employment through Career Based Intervention.] Graduates must under go an application and interview process and once hired, are paid $0.50 per hour. The work supervisor communicates regularly with the youth's treatment team to ensure that youth are maintaining a high standard of behavior and performance on the job. Available jobs include: cafeteria, storeroom, maintenance, porters for the living units, religious services, program services, school, recreation and cosmetology aides. An academic tutor, to be paid $0.90 per hour, will be added in the near future. Hours vary according to the Department's need and the youth's availability. Graduates may work up to 35 hours per week but must also ensure that they attend all required treatment programs. There are enough jobs available to support all youth who desire to have one.

Steps Taken to Assess Compliance	*Structured Programming* The previous Monitors' Report discussed the staffing problems that frequently disrupted the delivery of education and other programming. Fortunately, the staffing problems have been largely resolved. While the facility often uses mandated overtime to meet minimum staffing levels, they have been able to ensure sufficient staff are available to deliver all youth programs during the current monitoring period. Interviews with youth indicated that recreation and volunteer programs are delivered as scheduled, even though youth often wished for a different composition to the recreation program (e.g., wanting to be outside; wanting to be in the gym; more basketball; less basketball). If it does not already do so, the facility should implement a structured way to verify that recreation is delivered each day (e.g., this could be part of the UM's weekly report and/or the Superintendent's Monthly Report). These data should be presented to the Monitor for inclusion in the next Monitors' Report. A review of monthly activity schedules revealed a broad range of volunteer programs available to the general population youth at Scioto. These include religious services (Protestant and Catholic services; bible study; and other programs offering guidance to youth from faith-based organizations), gender-specific services for girls, academic tutoring, sports programs and a variety of creative/art programs. The activity schedules revealed that the programs are slated for delivery to all of the general population units on a rotating basis. Moving forward, the State needs to adopt the database being piloted at IRJCF so that it can demonstrate, to both the Monitor and the Release Authority, that the youth was engaged in a range of structured activities throughout their stay at Scioto. A sample of 10 youth's files from the CaseNotes database was requested to ascertain attendance rates for group and individual counseling during the month of September. While more detail will be provided in the Mental Health section of this report, the review of treatment participation was not encouraging: • Gang Intervention. This was the most reliably delivered group. Three of the youth participated in the 9 sessions that were held in September. Groups were held between 2 and 4 times per week. • Core A. Even though all youth are supposed to receive this group, only 4 of the 10 youth's participation was documented. Core A groups are held much more dependably on the girls' units (15 sessions in September) than the boys' units (2-4 sessions in September). • Core B. None of the 8 boys received this group. The two girls participated in the group 2 and 4 times, respectively, during September. • Core C. Two of the boys had entries for this group showing

	participation in 1 and 2 sessions, respectively, in September. • Healthy Relationships. As discussed in III.A.1, this 9-session group was delivered to the girls between August and October. There were 2 sessions in September. • Extended Stay. Three of the youth had entries for this group showing participation in 1, 2 and 4 sessions, respectively, in September. • Substance Abuse. Only one youth participated in this group, and only for one session. Another youth's notes indicated that he needed these services for parole, but was not yet enrolled. • Individual treatment. All 10 youth had entries, but the frequency and duration of the sessions varied. Nearly all of the youth had only one or two sessions in September, although one youth had 4 sessions. Most of the sessions were 30 minutes in length, or shorter. While the treatment contact standards and the extent to which they are being met will be discussed in detail in the Mental Health section of the report, it appears that this component of the facility's Programming initiative needs additional oversight to ensure that youth are engaged in the various groups at the expected frequency. *Programming for Graduates* Work records were reviewed for each of the 12 graduates currently housed at the facility (18% of the total population). One of the youth was pending transfer to CJCF and did not have a job. Across the other 11 youth, 5 were working the café, 3 were working as porters, 1 was working in the storeroom, 1 was working in maintenance, and 1 was assisting the Chaplain. Work schedules and timesheets verified that the youth had been consistently employed, often for several months. A list of vacant job positions included additional porter positions, school office aide, several maintenance positions and an academic tutor. The facility clearly has the capacity to accommodate more graduates with jobs, if needed. Attendance records indicated that all but two youth were enrolled in at least one of the college courses (most were enrolled in two or three). The two youth who were not enrolled were new to the facility and, because the courses are co-ed, needed to undergo a period of observation to ensure that no security risk would be presented by their attendance. Courses had been ongoing for both the 2012 Summer and Fall semesters and had sufficient capacity to serve more students, if needed. The facility has sufficient funding for at least one more semester of these programs and is currently seeking continuation funding so that the programs can continue and expand. Interviews with three students in

	the graduate program suggested tremendous satisfaction with the opportunities now available to them. Students who had been at Scioto for a long period of time kept reminding the new student, "You have no idea how much better things are now!!" The facility's progress in meeting the needs of Scioto graduates is reflected in the upgrade to Partial Compliance. *PROGRESS Unit (PU)* The upgrade to partial compliance is credited entirely to the improvements related to graduate programming; unfortunately, no improvements were evident in increasing the quantity of programming available to youth on the Progress Unit (PU). As discussed elsewhere in this report, the facility only attempted to meet the minimum requirements of this provision—for youth in closed-cell environments to be engaged in programming during all waking hours, except when in intervention seclusion—on October 15, 2012 when the 24-hour schedule was first implemented. Sufficient time has not yet passed to determine whether the schedule has been implemented with fidelity to its design and whether youth are accessing the range of programs designed to address their violent and aggressive behavior. Unfortunately, throughout the current monitoring period, the PU did not provide youth with dependable access to programming and services. Late in the monitoring period (June 2012), the facility began to emphasize with PU staff the need to bring the youth out of their rooms for school, recreation and treatment groups. However, a review of Unit Logs from the end of the monitoring period indicated that this effort was not particularly successful. While the PU was no longer operating as a 23-hour lockdown (as it had during its previous incarnation at another facility and during the early stages of its implementation at Scioto), PU youth still did not have dependable access to essential activities and remained locked in their cells far beyond the hours permitted by this Provision. The Sycamore Unit Log was reviewed for a 9-day period at the end of September 2012. A random sample of 4 youth (44% of the Sycamore population) was selected and the number of times each youth was engaged in various activities was tallied. The findings were discouraging: • Across the 9-day period, youth were engaged in recreation/unit leisure time an average of 4 times (range 3 to 5). Most youth did not receive recreation on the weekdays. All youth should have large muscle activity at least once per day. • Across the 9-day period, youth were engaged in a treatment activity (e.g., group or individual session) an average of 5 times (range 4 to 7). This is less than once per day and obviously counter to the idea of intensive programming, which should be

at the core of a special management unit if behavior change is truly the goal.

- Across the 9-day period, youth were offered showers an average of 7.25 times (range 5 to 8). While this may be a documentation problem, it highlights the difficulty the facility has had in offering and/or recording even the most straightforward activities on the PU.
- Youth appeared to be attending school consistently on school days, although sometimes it appeared that afternoon sessions were cut short.
- Meals were documented consistently, three times per day.

Considered another way, most of the youth on this unit attended in school on the weekdays and were involved in a single therapeutic activity after school about half the time, but remained locked in their rooms until the next morning the other half. On weekends, most youth were out of their rooms for only one or two hours each day.

A similar review was conducted using the Cedar Unit Logs during a 10-day period in late September 2012. A random sample of 5 youth (approximately 36% of the population, which fluctuated during the period reviewed) was selected and their engagement in various activities was tallied. The findings were somewhat better, but still far from sufficient to meet the requirements of this provision:

- Across the 10-day period, youth were engaged in recreation/unit leisure an average of 5 times (range 0 to 8). Most youth did not receive recreation on the weekdays.
- Youth were engaged in a treatment activity an average of 9.4 times (range 7 to 11), or about once per day.
- Youth were offered the opportunity to shower an average of 3 times (range 2 to 4). Again, this may be a documentation problem, but highlights the difficulty the facility has had in offering and/or recording even the most straightforward activities on the PU.
- Youth attended school for a full day each weekday. The one exception was a youth who was a graduate, who remained in his room throughout the school hours.

Note that the time period reviewed was well <u>after</u> DYS enhanced the PU staffing and began to emphasize the need for out-of-cell time. One can assume that services to PU youth were similarly limited during the early part of the monitoring period, before the DYS had even begun to rethink its program implementation strategy. Thus, during the current monitoring period, on the typical weekday, PU youth spent approximately 16 hours in their rooms. While 11 of these hours were sleeping hours, the other 5 were hours during which the State should have been providing access to treatment, recreation and other structured programming designed to rehabilitate youth and facilitate

	their return to the general population. On the weekend, most youth spent about 22 hours in their rooms, remaining idle and secluded during the approximately 11 hours that should have been used to deliver programming. Further, the PU has a dearth of programming for youth who have graduated from high school or obtained a GED. For security reasons, none of the programs that have been developed for the general population are available to youth housed on the PU. As a result, while their counterparts are in school, graduates spend most of the weekdays in their rooms. In the past, youth have reported the dearth of programming to be a disincentive to their completing their degree requirements, which is obviously counter to the overall intent of the Stipulation and DYS' own mission. This situation must be rectified immediately. In the original concept, the programming on the PU was supposed to be intensive. However, the vast amount of time that youth on the PU spend in their rooms has interfered with the delivery of services and the PU has not been capable of creating the kind of behavior change needed for the youth housed there to be integrated into the general population. The sad irony is that these youth are the most in need of services, but yet are receiving the least amount of service of any youth at Scioto. This situation must be rectified—youth must be out of their rooms, attending treatment, education or other structured programming throughout the day. The programming must be delivered with integrity so that youth learn to control their aggressive behavior without the imposition of the security features of the PU and are able to return to the general population within a reasonable period of time. Given the long-history of non-compliance with this provision, a significant period of time in which youth are actively engaged in structured programing throughout their waking hours will be needed to demonstrate that the changes are durable and that the State is capable of delivering the 24-hour schedule even as the youth characteristics and size of the population changes.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop the capacity to track youth's involvement in volunteer and religious programming and to ensure that recreation programming is delivered at the required frequency. 2. Ensure that individual and group treatment is delivered at the required frequency and duration on all units. 3. Ensure that youth on the PROGRESS Unit are out of their rooms, attending treatment, education or other structured programming throughout the day. Develop quality weekday program for youth who have graduated from high school or

	obtained a GED. This programming must be delivered with integrity so that the youth are able to meet their treatment goals and return to the general population within a reasonable period of time.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.1, prepared at my request • CaseNote records for 10 randomly selected youth housed at Scioto on October 18, 2012 • Work schedules, timesheets and job descriptions for all 12 graduates housed at Scioto as of October 15, 2012 • Course descriptions and attendance records for all post-secondary courses for the Summer and Fall semesters 2012 • Interviews with 15 youth housed at Scioto on October 19, 2012 • Draft schedule for the PROGRESS Unit, as of October 15, 2012

III.F.2 Orientation. a) Admissions Intake and Orientation. The State shall develop and implement policies, procedures and practices to establish a consistent, orderly admissions intake system, conducive to gathering necessary information about youth, disseminating information to staff providing services and care for youth, and maintaining youth safety. The orientation shall also clearly set forth the rules youth must follow at the facility, explain how to access medical and mental health care and the grievance system, and provide other information pertinent to the youth's participation in facility programs. b) Notice to Youth of Facility Rules and Incentives/Consequences for Compliance. The State shall explain the structured programming to all youth during an orientation session that shall set forth the facility rules, the positive incentives for compliance and good behavior and the sanctions for rule violations. The State shall provide the facility rules in writing. c) Introductory Handbook, Orientation and Reporting Abuse. Each youth entering the facilities shall be given an orientation that shall include simple directions for reporting abuse and assuring youth of his/her right to be protected from retaliation for reporting allegations of abuse.	
Compliance Rating	Partial Compliance
Self Assessment	The facility continues to audit a random 10% sample of admissions files every month to ensure compliance with policy and procedure. Between April 2012 and September 2012, approximately 300 youth were admitted to the facility; 10%, or 30 youth, were included in the audit. Each month, 100% of the youth sampled received a complete orientation to the facility which included, among other things: • Youth Handbook • Orientation Video • Facility rules and consequences (IRAV) • Strength Based Behavior Management System (SBBMS) • Obtaining legal assistance • Accessing medical and mental health care • Sexual abuse and sexual assault information • Grievance system
Steps Taken to Assess Compliance	*Religious Accommodations* The previous Monitor's report required the State to provide youth with information that clearly described the youth's rights related to practicing their religion of choice, in particular, how they make seek accommodations for religious beliefs, practices or observance. The State revised the handbook by inserting the following language: *Every youth has the right to practice their religion. You are permitted to have the resources of your faith as long as it does not affect the safety of the facility.* The revised Handbook was put into use on January 12, 2012. Department

	heads and supervisors provided information to their staff on the requirement to accommodate youth's religious beliefs. As of March 15, 2012, 87% of all staff had been trained and completed a post-test about the facility's religious accommodations policy. During the current monitoring period, three grievances were submitted by youth who wanted the freedom to practice their religion of choice. • A youth requested a copy of the Holy Quran, and was dissatisfied that he'd received the Glorious Quran (the two versions have the same content, but different covers, per an area Islamic bookstore). The youth was provided with this information, accepted the Glorious Quran and was also permitted to receive a copy of the Holy Quran from his parents if he preferred. • A youth requested permission to grow his hair into dreadlocks in order to practice his faith, Rastafarianism. An application for religious hair accommodation was submitted on his behalf and an appointment with the cosmetologist was scheduled so that he could learn the proper techniques to care for his hairstyle. • A youth indicated that he is Muslim and therefore should be exempt from facility policies that require him to shave. The Chaplain consulted with the youth, who retracted his request, indicating that "Islam is too confusing to follow." The revised Youth Handbook clearly articulates that youth are free to practice their religion of choice and the facility has demonstrated its willingness to make religious accommodations when the issue has arisen. *PROGRESS Unit Orientation* While most of the youth at Scioto undergo an orientation to the general population, youth can also be admitted directly to the PROGRESS Unit (PU), and thus the orientation for that program is relevant to this provision. Draft SOP 303.01.07 "Progress Unit" requires the Unit Manager to ensure that the PU Youth Handbook is available to all youth and that a staff member provides a thorough orientation to youth upon their admission to the Unit. Youth must sign the Handbook's signature page to acknowledge receipt of the information. The PU Handbook remains in draft form, along with the SOP. Given the recent modifications to the PU program (discussed in III.A.3 and III.F.1, above), the draft Handbook will need to be revised from its current incarnation, and finalized along with the SOP, in order for the State to reach substantial compliance with this provision. [The PU has never been governed by a formal policy—it has only ever existed in draft form. Once initially signed into effect, subsequent modifications to the SOP or the Handbook to keep pace with the program's evolution will not cause the State to fall out of substantial compliance.]

	To assess the extent to which youth admitted to the PU received an orientation (even if it is not yet required by policy), Orientation Acknowledgement Forms were requested and reviewed for the 17 youth admitted during the monitoring period, April through September 2012. Signed orientation sheets were available for all of 17 youth. At times, the dates on the sheets curiously pre-dated the youth's transfer to the unit. Additional investigation revealed that the youth's transition dates were not entered immediately upon their placement. While this problem does not affect compliance with this provision, it should be rectified given that the length of stay on the PU is a topic of much concern and it is important for admission dates to be correct.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Finalize the PU Youth Handbook and SOP so that they provide an accurate description of the current operation of the PROGRESS unit.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.2, prepared at my request • Intake Audit Report, April 2012 through September 2012 • Scioto Youth Handbook, last modified March 16, 2012 • Grievances related to religious accommodation (n=3), submitted between April and September 2012 • Admission dates and orientation records for youth admitted to the PROGRESS Unit since April 1, 2012

MENTAL HEALTH SERVICES

III.B. 1 Mental Health Screening. The State shall implement policies, procedures and practices to ensure that all youth admitted to the facilities are comprehensively screened for mental disorders, including substance abuse, depression, and serious mental illness, within twenty-four hours of admission. This screening shall be performed by qualified personnel, as part of the intake process, consistent with generally accepted professional standards of care.	
Compliance Rating	Substantial Compliance
Self Assessment	Per the SJCF oral self-assessment, policy and procedure regarding this process remains pending.
Steps Taken to Assess Compliance	Per a review of ten intake packets provided for off site review revealed that all youth admitted had Reception Screening for Assaultive Behavior, Sexually Aggressive Behavior, and Risk for Sexual Victimization on the day of admission. Substance Abuse Screening was included via documents, such as the Juvenile Automated Substance Evaluation. It was notable that every assessment example provided recommended further assessment by psychology staff to complete a Behavioral Health Appraisal. The intake packets initially provided for review did not include documentation of the immediate screening by nursing staff, nor did they include MAYSI-2 results. Following submission of the draft report, nursing screening and MAYSI results were provided for review. These were completed appropriately with the exception of the date on the MAYSI screen. Each document had a sticker with the youth's name and date of admission; however, the space on the MAYSI form where the date was to be entered was blank in five out of ten examples. Per discussions, it was determined that the MAYSI is performed on the date of admission; however, as discussed with ODYS administrative staff, it is necessary for the date blank to be completed by the individual administering the MAYSI and any other assessment documents. This is an issue that should be followed via ongoing QA. Per interviews performed during the previous monitoring visit, it was apparent that current policy and procedure regarding this process was confusing, mostly related to the multiple assessment documents and terminology utilized. In an effort to address this issue, and to simplify all Behavioral Health policies, ODYS promoted a review and revision of all policies with the involvement of central office leadership, facility administration, and facility behavioral health staff. Individuals were assigned to work groups with responsibility to review and revise policy as part of an integrated behavioral health system of care. The final policy was pending; however, per discussions with behavioral health administrative staff, policies and procedures have been completed, and are in the final stages of review with full implementation planned for the first quarter of 2013.

	Please note that throughout the mental health report, there are multiple references regarding the need to finalize policy and procedure. While policy and procedure is in existence and has been implemented to address processes associated with the delivery of mental health care, ODYS is currently in the final process of a review and simplification of said policy. As such, the recommendation for finalizing policy is in reference to the revision and simplification process. There are existing policies in place that are fully implemented and as such the individual provisions below would meet the criteria for a partial compliance rating. The plan to simplify policy and via this process integrate the various mental health disciplines into a behavioral health team is positive and may result in more cohesive mental health treatment for the youth. While it is apparent that multiple assessment instruments are utilized for youth admitted to ODYS, this remains a complicated process, highlighting the need for policy and procedure revision and quality assurance monitoring.
Recommendations	In order to maintain substantial compliance with this provision, the State must: 1. Fully implement policy and procedure "Behavioral Health Assessment, Screening, Appraisal and Evaluation." Given the change in facility mission, review and revise this policy as necessary. 2. Begin quality assurance monitoring or clinical supervision regarding the reception assessment summary documents. 3. Begin quality assurance monitoring to ensure that timelines required by policy and procedure are adhered to.
Sources of Information	• Review of provided documents • Staff interview

III.B.2 Immediate Referral. If the mental health screen identifies an issue that places the youth's safety at immediate risk, the youth shall be immediately referred to a qualified mental health professional for assessment, treatment and any other appropriate action, such as transfer to another, more appropriate setting. The State shall ensure that, absent extraordinary circumstances, qualified mental health professionals are available for consultation within 12 hours of such referrals.	
Compliance Rating	Substantial Compliance
Self Assessment	Per the oral facility self-assessment, facility mental health staff were using central office as a "safety net" in order to effect transfers to other programs if necessary. There were examples provided of youth transferred to other facilities to access programs.
Steps Taken to Assess Compliance	This was an area of ongoing improvement in the intervening period since the previous monitoring review. Discussions with behavioral health staff revealed that they felt empowered to advocate for the youth in the facility without fear of reprisal. There were examples of active advocacy noted. For example, previously, if a youth were suspected of acute mental health needs requiring transfer to the mental health unit, there was a cumbersome process to arrange this transfer. With recent shifts in process and administration, this is now reportedly a relatively painless process. For example, in April 2012, Youth #404 was assessed on intake at SJCF and noted to be experiencing symptoms of psychosis. He was immediately referred for transfer to the mental health unit. In May 2012, Youth #505 was assessed on intake at SJCF and noted to have a developmental disability. He was immediately referred for transfer to the life skills unit. In September, two additional youth were identified at intake at SJCF as having developmental disabilities and referred to the life skills unit. In September 2012, Youth #606 experienced an exacerbation of mental health symptoms and was transferred to a behavioral health facility for acute care. Given the review of the current behavioral health staff schedule, staff are working a flex schedule with one required evening per week and one required weekend per month. This allows for broad behavioral health coverage. One weakness of the schedule was the lack of behavioral health staff scheduled on holidays. There was an on-call schedule, and the Psychology Supervisor was responsible for this, specifically after hours telephone contact. The Psychology supervisor was also reportedly available to come to the facility for face-to-face assessments if the need arose. Given the review of documents performed for this and other paragraphs, it was apparent that there was an improvement in referral to a mental health provider, response from mental health providers, and access to other mental health treatment programs as needed. As

	such, this provision will be placed in Substantial Compliance. In order to maintain this level, ongoing efforts must be made to ensure that youth obtain the level of care that is necessary. In addition, quality assurance monitoring will be necessary with regard to timely response to referral and access to other behavioral health care options.
Recommendations	In order to maintain substantial compliance with this provision, the State must: 1. Collect data regarding the time lapse between referral and actual evaluation or assessment for quality assurance monitoring. 2. Ensure that staff are aware of the process by which a youth may access other appropriate mental health services (e.g. a facility based mental health unit or an inpatient psychiatric facility).
Sources of Information	• Review of provided documents • Observation • Staff interview

III.B.3 Identification of Previously Unidentified Youth. The facilities shall implement policies, procedures and practices consistent with generally accepted professional standards of care to identify and address potential manifestations of mental or behavioral disorder in youth who have not been previously identified as presenting mental health or behavioral needs requiring treatment.	
Compliance Rating	Partial Compliance
Self Assessment	Per the facility oral self-assessment, the majority of youth assigned to the Progress Unit (18 out of 20) were on the mental health caseload. There were a total of ten female youth, with all of them on the mental health caseload. The total facility population at the time of the monitoring visit was 72. The mental health roster indicated that there were a total of 50 youth (70%) assigned to the mental health caseload.
Steps Taken to Assess Compliance	With regard to the identification of youth previously unidentified as having mental health challenges, the facility has made changes to the facility environment in an effort to ensure that all youth requiring services are identified as such. For example, there are behavioral health staff (both psychology and social workers) housed on the units. There was also enhanced mental health presence on the Progress Units. A full time mental health nurse began providing services at the facility approximately one month prior to the end of the monitoring period. He has been assigned to the Progress Unit and performs rounds every weekday. Also, a psychiatrist has been assigned to the Progress Unit, beginning work there approximately two weeks prior to the end of this monitoring period. In addition, facility staff were performing daily mini mental status reviews for youth housed on Phase One of the Progress Units. These reviews serve several purposes, to monitor youth housed in this area for decompensation, to identify youth requiring mental health intervention, and to ensure access to health care for those youth housed on that unit. It should be noted that late in the monitoring period, youth were allowed out of their cells on a daily basis for increasing amounts of time, which is positive. As this progresses, and youth are out of their cells for the majority of their waking hours, the need for daily mini mental status reviews will be reduced. Administrative behavioral health staff instituted a comprehensive screening process for those youth proposed for placement on the Progress Unit. This process began during the summer of 2012; however, became more extensive during the late fall. It is noted that this process has improved overall since October 2012; however, needs additional time for assessment prior to achieving Substantial Compliance. A review of the total number of youth currently on the mental health caseload revealed that 10/10 female youth (100%) were identified.

	With regard to male youth 40/61 (65%) were identified. Additionally, via a review of the caseloads of psychology staff assigned to the Progress Units, it was apparent that 90% of the youth currently housed on those units were identified and currently receiving mental health services. Additional information received via the document request revealed that in the intervening period since the previous monitoring review, "there have been no youth initially assigned to the general population who were then identified as requiring mental health services." As discussed in the ensuing provisions there are several examples of assessment and diagnostic issues which are concerning. More prevalent was potential minimization of mental health issues and their contribution to challenging behavior. The goal of this provision was to ensure that youth who may not present with a history of mental illness and who are not identified at the time of initial assessment as being at risk for mental illness or behavioral challenges, are monitored over the course of their incarceration for exacerbations of symptoms and referred for mental health treatment. Administrative staff were aware of the need for ongoing and improved quality assurance to review documentation and the decision making process regarding youth mental health needs. As discussed in provision 4 below, multiple assessment documents were being generated, however, there was wide variability with regard to case formulations reviewed in the documents that tied all the information obtained together in a coherent package for the reader. This was an area that would be amenable to quality assurance, peer review process and clinical supervision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Quality assurance monitoring regarding re-evaluation of youth who experience an exacerbation of mental health symptoms or behavioral challenges. 2. Ensure the creation of a case conceptualization for each youth. 3. Ensure that direct care staff and behavioral health staff are trained to recognize and respond to signs and symptoms of serious mental illness. 4. Maintain the practice of the comprehensive screening of all youth proposed for placement on the Progress Units.
Sources of Information	• Review of provided documents (e.g. Policy and Procedure, draft Policy and Procedure, youth records). • Staff interview

III.B.4 Mental Health Assessment. The State shall implement policies, procedures and practices to ensure that, as part of an overall assessment of the youth's health, risks, strengths and needs, youth who are identified in screening as having possible mental health needs receive timely, comprehensive and accurate assessments by qualified mental health professionals, consistent with generally accepted professional standards of care. Assessments shall be designed and implemented so as to identify youth with mental disorders in need of specific treatment and contribute to a full plan for managing the youth's risk. Assessments shall be updated as additional diagnostic and treatment information becomes available.	
Compliance Rating	Partial Compliance
Self Assessment	Per the oral facility self assessment, staff participated in a training regarding case formulation. ODYS central office staff has engaged in review of some of these documents.
Steps Taken to Assess Compliance	Per the previous monitoring report, policy and procedure entitled "Behavioral Health Assessment, Screening, Appraisal and Evaluation" was in the process of review and revision. This was necessary not only due to omissions in the previously authored documents, but due to the change in mission incurred at SJCF. This policy, along with others regarding Behavioral Health services have been reviewed and revised in a collaborative manner between ODYS administration and facility behavioral health staff. The policies were submitted to the monitors for review and comment. The final drafts of these documents was pending at the time of this monitoring review. A necessary part of any mental health assessment is the case conceptualization or diagnostic formulation. This information is intended to review specific symptoms experienced by the youth in order to justify a specific diagnosis. In addition, the diagnostic formulation or case conceptualization must integrate relevant factors impacting a youth's development/behavior/mental status, including biological, psychological, social, and cultural perspectives that can be utilized by the clinician to identify specific risk factors or targets for ongoing behavioral and mental health therapies. From this information, an individualized and integrated treatment plan could be derived. Nine examples of case formulations were provided. The quality of these documents as well as the psychological services summary was variable and would benefit from quality assurance monitoring. For example, the case formulation regarding Youth #303 dated 9.23.12 was reviewed. This formulation provided a great deal of information with regard to this youth's legal history and family history. There was also information regarding his progress during his stay at the facility. The document indicated this youth spent nine months on the Progress Units, and that he had received multiple intervention hearings accruing 295 additional days. There was mention of a cannabis abuse diagnosis at the time of admission on 6.23.11; however, as of the date of this case formulation, he was not scheduled into this treatment modality, and it was planned

	for this to occur following his release from the facility. As substance abuse is a serious risk factor for recidivism, it was not acceptable that this youth's need in this risk area was not addressed during his lengthy stay at the facility. This youth was additionally diagnosed with mood disorder, not otherwise specified and conduct disorder. The case formulation did not review specific symptoms that this youth was experiencing. There was notation that this youth was prescribed mood stabilizing medication, leading the reader to question if this youth would meet criteria for a diagnosis in the bipolar spectrum. This, along with his history of behavioral challenges raises concerns that a misdiagnoses and possible under treatment of his mental health disorder served to exacerbate unrecognized mental health symptoms prolonging his incarceration. This case formulation was variable with regard to quality; it evidenced good information, but did not tie this information together such that it could be utilized for treatment planning. As indicated in the previous monitoring report, despite the generation of multiple assessment forms, there was the need for a document to tie all the information obtained together in a coherent package for the reader, treatment team, or future treatment provider inclusive of a diagnostic formulation or case conceptualization. The current documentation was an attempt to improve upon that process, but there is work to be done from a quality perspective. It is hoped that ongoing training inclusive of peer review and quality assurance monitoring regarding this process will be beneficial for staff.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue and expand quality assurance measures including a peer review process and clinical supervision to ensure the development of a case conceptualization that ties together information gleaned in the assessment process. 2. Consider individual clinical supervision and training regarding the assessment process and development of the case formulation. 3. Ensure that behavioral health staff are aware of the necessary components of a quality case formulation. 4. Begin quality assurance monitoring of case formulations and resultant ITP documents. 5. Review and revise policy and procedure to reflect the requirements of this provision and the new facility mission.
Sources of Information	• Review of policy and procedure • Review of youth records • Review of other provided documents • Staff interview

III.B.5 Adequate Mental Health Care and Treatment. The State shall implement policies, procedures and practices to ensure that adequate mental health and substance abuse care and treatment services (including timely emergency services), and adequate rehabilitative services are provided to youth in the facilities by qualified mental health professionals consistent with generally accepted professional standards of care.	
Compliance Rating	Partial Compliance
Self Assessment	Per the oral facility self-assessment, they have engaged in modeling and coaching for youth specialists responsible for group therapies. Evidence of these trainings was not provided for review. Staff also indicated increased mental health contact hours for youth housed on the Progress Units. They reported 16.5 hours average per month for the four months prior to the monitoring visit. Actual data were not provided for review.
Steps Taken to Assess Compliance	In reviewing the Freedom New Phoenix Cognitive Behavioral Health program curriculum, the inclusion of direct care staff is vital to the success of the program. Per the observation conducted during this monitoring period, documents provided and the self-assessment, it was reported that youth specialists are being integrated into treatment team meetings to further involve them in group process and gather information regarding their observations of youth (see the discussion below regarding III.B.7 for additional information). Youth specialists facilitate CBT groups on the units. Unfortunately, due to time constraints during this monitoring visit, it was not possible to observe a youth specialist facilitated group. Historically, there has been variability in the ability of staff and additional training, coaching, modeling was required. Historically, basic tenets of effective group facilitation were not utilized consistently, these included environment, review of group rules, direction of group topic, and engagement of the youth. Per the administrative staff interviews, additional training via modeling and coaching was provided. Quality assurance measures inclusive of treatment integrity checks with resultant corrective action were reportedly not occurring. Following these reviews, the training provided to youth specialists with regard to group facilitation may need to be reviewed and revised in order to ensure that principles are being appropriately addressed. With regard to group therapeutic interaction facilitated by behavioral health staff, two group therapy sessions were observed on the Progress Units. The first group was led by a social worker, and included a total of five youth. The focus of the group was aggression and violence. The social worker made good attempts to engage the youth, ultimately engaging all, even a youth who was initially disruptive to the group process. The youth appeared to enjoy the group interaction, which was enhanced by the social worker asking them questions and encouraging

	all to participate. The social worker took the youth's lead, and integrated cognitive behavioral techniques into the discussion. This was a good group therapy example. The second group therapy observed was a trauma group facilitated by psychology staff. Four youth participated. This group started twenty minutes late. The group began with a review of the youth's "distress thermometer" where youth were asked to rate their level of current distress on a scale of 1 to 10 with ten being extreme. One youth rated himself a 10, and the group leader did not ask any further questions or engage this youth. The distress thermometer was not discussed further, and therefore the purpose of this activity was not clear. Ultimately, two senior mental health staff sitting in as observers to the group began to interject in an effort to make the group personal and meaningful to the youth. Prior to their intervention the group was superficial and cursory with little useful or meaningful information provided. At the completion of the group, the facilitator again reviewed the "distress thermometer" and again took little note of the youth who again rated himself as a 10. Senior mental health staff encouraged the facilitator to follow up with this youth following the group. This was an example of a poorly run group, where youth were not engaged, and there was little evidence of a therapeutic group process. This group functioned less as an interaction between staff and youth and more like a lecture or education regarding specific concepts. There were multiple opportunities for the facilitator to explore specific topics with the youth; however, these were not utilized. The first group observation revealed that there are skilled group therapy providers who could provide role modeling to other less experienced clinical staff. Additionally, they could assist with the development of activities to enhance the youth's participation in the group therapeutic process. All of the above indicate the need for quality assurance monitoring inclusive of observation and coaching for both behavioral health and youth specialist staff. With regard to the number of scheduled groups and the number of youth participating in any one group therapy encounter, this was discussed in detail in the discussion regarding paragraph III.B.11 below. There was documentation of attendance at groups that exceed recommendations for conducting a meaningful group interaction. It was recognized that this was occurring less frequently than in previous monitoring reviews. Concerns remain with regard to appropriate diagnostic assessment, case formulation, and treatment plan development. For example, a review of the mental health roster revealed that out of a total of 40 youth, there were 15 youth with diagnoses documented as "not otherwise

	specified." This was concerning and may indicate the need for refinement in the diagnostic process. In fact, Youth #222 and Youth #202 each had three "not otherwise specified" diagnoses. These are non-specific diagnoses and may represent a cursory diagnostic process or lack of an appropriate case formulation for diagnostic purposes. This is another area where systematic quality assurance monitoring would be beneficial. Review of progress notes regarding both group process and individual treatment was limited during this monitoring visit, as youth records were not provided for off site review. Rather, there were isolated examples of youth individual therapy progress notes provided as examples for other items. In review of these documents, there was variability in the quality of the documentation, the duration of the therapeutic interactions and the frequency of the therapeutic interactions. Some mental health providers were noted to meet frequently with youth for brief periods of time (15 minutes to 30 minutes), where others met less frequently for longer periods (45 minutes). A review of treatment planning documents did not reveal consistent documentation regarding the level of care or frequency of interaction prescribed for each individual youth. Therefore, it was not possible to determine if the frequency noted via record review was appropriate for a particular youth. Given the above, it was apparent that while some treatment was occurring, improvements to the overall treatment program and documentation of treatment planned and provided will be necessary for the facility to meet the requirements of this provision. Specific concerns were noted regarding the treatment program for youth housed in the Progress unit during this and prior monitoring visits. It was noted that given the increased presence of behavioral health staff on these units with the corresponding decrease in youth census on these units that there should be improvement in the overall monitoring and treatment provided for these youth. There remained issues with youth receiving regularly scheduled individual therapy. For additional information regarding this, please see the discussion under III.B.18. As discussed with the facility administration, facility mental health staff and DYS administration, the programming on this unit must continue to be a priority and will be the focus of future monitoring visits.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Improve documentation of group and individual therapeutic interaction and review this documentation via a quality assurance process. 2. Ensure the provision of evidence based group therapeutic interactions. 3. Increase modeling and coaching for youth specialists responsible for

	group therapeutic interactions. This should include group therapy observation and resultant corrective action inclusive of training, supervision, etc. Administrative staff may determine that revised training for youth specialists is required. 4. Determine and ensure that appropriate numbers of youth are assigned to specific group therapy sessions. 5. Continue the integration of treatment provider disciplines in order to achieve an interdisciplinary model. 6. Continue to engage and encourage direct care staff to participate in group modalities and in the overall treatment program for the youth. 7. Begin quality assurance monitoring regarding the mental health treatment program that addresses both adherence to the required procedural elements but also measures youth outcomes related to the treatment modality (e.g. reduction in SHU referrals, reduction in facility violence). This should also include treatment integrity reviews. 8. Review the Progress program, and ensure that youth are receiving appropriate mental health treatment via this program. 9. Review and monitor youth case formulations and diagnoses via a quality assurance program.
Sources of Information	• Review of provided documents (e.g. group schedule, youth records, policy and procedure, description of treatment modalities) • Observation of two group interactions • Youth interview • Staff interview

III.B.6 Treatment Planning. The State shall develop and implement policies, procedures and practices so that treatment service determinations, including ongoing treatment and discharge planning, are consistently made by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated treatment plan.	
Compliance Rating	Partial Compliance
Self Assessment	Per the oral facility self assessment, the facility has engaged in training for staff with regard to treatment planning. Policy and procedure revisions are pending, as is formal quality assurance monitoring. There has been review of treatment planning documentation via central office.
Steps Taken to Assess Compliance	As part of the ODYS Behavioral Health administrative review, there are plans for continuing monitoring with regard to the authorship of ITP documents. As discussed in paragraph 18 below, the facility must develop a quality assurance process to review both compliance with process and to determine outcomes associated with behavioral health treatment. For additional discussion regarding Treatment Planning and IDT meetings, please see the discussion regarding the provisions below (7 and 8).
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review, revise, and implement policy and procedure regarding treatment planning and the IDT process. 2. Develop quality assurance monitoring regarding ITP development, implementation, and progress. 3. Address recommendations provided regarding provisions 7 and 8 below.
Sources of Information	• Staff interview • Review of provided documents

III.B.7 Treatment Teams. At a minimum, the interdisciplinary treatment team for each youth in need of mental/behavioral health and/or substance abuse treatment should: a) be guided by a trained treatment professional who shall provide clinical oversight and ensure the proper functioning of treatment team meetings; b) consist of a stable core of members, including at least the youth, the social worker, a JCO, one of the youth's teachers, the Unit Manager, and as warranted by the needs of the youth, the treating psychiatrist, the treating psychologist, registered nurse, and, as appropriate, other staff; c) ensure that needed psychiatric evaluations are conducted on a youth before administering psychotropic medications to the youth; d) monitor as appropriate but at least monthly, the efficacy and the side effects of psychotropic medications, including consultation with family medical, counseling and other staff who are familiar with the youth; e) for youth under a psychiatrist's care: ensure the provision of individual counseling and psychotherapy when needed, in coordination with facility psychologists; ensure that all youth referred as possibly in need of psychiatric services are evaluated and treated in a timely manner; and provide adequate documentation of treatment in the facility medical records; f) include to the fullest extent practicable, proactive efforts to obtain the participation of parents or guardians, unless their participation would be inappropriate for some reason (e.g., the child has been removed from the parent's custody), in order to obtain relevant information, understand family goals and concerns, and foster ongoing engagement; g) meet to assess the treatment plan's efficacy at least every 30 days and more often as necessary; and h) document treatment team meetings and planning in the youth's mental health records.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was delivered orally during the monitoring visit. Per staff interviewed, the psychiatrist has been participating in treatment team (IDT) on the Progress Units for the past week. There has not been psychiatric participation for treatment team regarding youth housed in general population. In the absence of the psychiatrist, mental health nurses have been attending IDT when they are able and providing information to the treating psychiatrists. Staff indicated that family members attended IDT regarding one youth on the Progress Units. They indicated that effort had been made to include family members in IDT meeting on the female unit, but this had been unsuccessful due to technological issues.
Steps Taken to Assess Compliance	One treatment team meeting was observed during this monitoring visit. There were no representatives from the school participating. The youth's parents were not in attendance. Other necessary staff, including the newly hired psychiatrist were present. The IDT reviewed the youth's recent behavioral challenges. There was limited discussion with regard to the reason or contributing factors to the youth's behavior. Staff were knowledgeable regarding the youth's behavior, but did not appear to have a deeper understanding of the youth's issues and underlying motivations. For example, Youth #888 was reportedly not adhering to the prescribed medication regimen. It was discussed that he was declining to take his morning medication because, "he just doesn't feel like coming to the door." It was noted that after

	two missed dosages, "he struggled in class and was asked to leave due to being irritable." Staff did a cursory review of this issue and moved on to the next youth up for discussion. There was no indication that anyone had a meaningful discussion with this youth in order to determine the reason he had begun to refuse his morning medication (e.g. side effects, bedtime medication causing morning sedation, treatment resistance, etc.) It was noted that several youth were experiencing difficulties that staff attributed to psychotropic medication. ITP goals do not regularly include treatment with psychotropic medication, which should be added to the ITP for those youth with prescribed psychotropic medications. As the psychiatrist becomes an integral part of the IDT, it is hoped that these issues can be addressed in concert with him. A review of the IDT minutes for the three months prior to the monitoring visit revealed scant detail of the meeting. For example, the IDT minutes from Allman unit dated 9.5.12 include details regarding "announcements and accomplishments" for the unit. Information regarding the three youth reviewed stated, "went over youth's goals and objectives" for two youth, and for the third, "youth was brought in to discuss her job suspension for three weeks." This documentation was not reflective of a rich IDT meeting. IDT minutes generated on Cedar Unit 9.18.12 revealed ongoing attention to "announcements and accomplishments" but also included information regarding each youth's goals. There was also documentation regarding the youth's progress toward goals. For example Youth #101 "is having issues in all areas and making little or no progress." There was also documentation that this youth was "not accepting responsibility for his actions…needs to work on peer pressure issues and criminal thinking…" The minutes did not include information regarding the IDT's plan to address these issues with the youth, or what interventions would be added or changed to allow this youth to acquire the skills necessary to progress. There was an obvious need for better integration of services and the formulation of a collaborative case conceptualization so that all team members could "be on the same page" with regard to the management of this youth. In previous monitoring reports, a shortcoming addressed was that in general: *IDT minutes reflected significant time spent in the discussion of "housekeeping" issues such as the unit schedule and youth rules. With the exception of the girls mental health unit (where documentation of IDT addressed youth mental health issues) documented discussions, particularly regarding mental health treatment issues appeared to be minimal. This had improved over prior visits. Per discussions with ODYS*

	Behavioral Health administrative staff, there were plans to move the discussion of unit issues to the end of the IDT meeting in order to minimize the "housekeeping" discussion and highlight the importance of the youth's treatment. One of the recommendations from the March 2011 report was to integrate youth specialists into weekly IDT meetings. The self-assessment reported "a QI process was implemented regarding the integration of direct care staff…there has been an increase in Youth Specialist presence and involvement in all Interdisciplinary Teams." Unfortunately, results of this QI process or other quality assurance monitoring regarding IDT meetings were not presented for review. During the observed IDT meeting, youth specialists were present and were noted to participate in the discussion. This was indicative of some effort to include all disciplines in review and planning of youth treatment. Reportedly due to an ongoing paucity of psychiatric resources, the psychiatrist was not a participant in IDT meetings. Psychiatric nurses were attending IDT in lieu of the psychiatrist. This had been remedied on the Progress Units. Approximately one week prior to the monitoring visit, additional psychiatric resources had been obtained, with plans for this new staff member to focus his attention on the Progress Units inclusive of attendance at the IDT meetings.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure psychiatric resources are available to allow participation in Interdisciplinary Treatment Team meetings for all youth assigned to the mental health caseload. 2. In an effort to maximize the use of staff resources, separate administrative or "housekeeping" discussions from IDT meetings. 3. Increase efforts to include the youth's parent or guardian in the treatment planning process. 4. Ensure that direct care staff are included in and valued members of the IDT. 5. Ensure that all necessary staff disciplines participate in IDT, inclusive of educational staff. 6. Begin Quality Assurance monitoring of treatment planning efforts and IDT meetings. This would include the development of both process and outcome measures inclusive of trending data and corrective action where necessary. 7. Increase staff training/education regarding the timely formulation of a treatment plan and interventions developed as a result of, among other things, the discussion in IDT. These plans must then be implemented, first via training direct care staff.

Sources of Information	• Staff Interview • Observation of Interdisciplinary Treatment Team meeting • Review of provided documents • Youth interview

III.B.8 Integrated Treatment Plans. The State shall ensure that each youth in need of mental/behavioral health and/or substance abuse treatment shall have an appropriate, integrated treatment plan, including an appropriate behavior management plan that addresses such needs. The integrated treatment plan shall be driven by individualized risks and needs, be strengths-based (i.e., builds on an individual's current strengths), account for the youth's motivation for engaging in activities contributing to his/her wellness, and be reasonably calculated to lead to improvement in the individual's mental/behavioral health and well being, consistent with generally accepted professional standards of care.	
Compliance Rating	Partial Compliance
Self Assessment	Per the oral facility self-assessment, staff have received training on the integrated treatment plan (ITP) process inclusive of case conceptualization. It was reported that policy and procedure regarding ITP's remained pending at the time of the visit.
Steps Taken to Assess Compliance	Document review revealed some improvement in ITP documentation. Specifically, youth strengths and measurable goals were identified on some documents. There was room for improvements with regard to ensuring goals were measurable. In some of the examples, interventions were identified; however, they did not routinely address skills the youth needed to acquire in order to achieve the goal. Rather, they included workbook assignments or other tasks the youth was to complete. In addition, mental health and medication management goals were not routinely addressed. For an example of this, please see the discussion in provision G1 regarding Youth #111. In a second example, the ITP regarding youth #888 did not include information regarding this youth's mental health diagnoses, or treatment with psychotropic medications. He has diagnoses including mood disorder, not otherwise specified and posttraumatic stress disorder. He is prescribed atypical antipsychotic medication. One of Youth #888's goals was to "demonstrate healthy sexual boundaries with females within ODYS." The objective stated, "I will not expose my penis to any female for the next 14 days…monitoring by not receiving an YBIR's for sexual conduct or sexual assault within that 14 days….If I feel the urge to expose myself or masturbate in front of a female while on progress, I will complete a decisional balance worksheet and process the information with my social worker during weekly individual sessions. I will talk to my behavioral health [sic] at least one time per week during my sexual misconduct urges." This treatment intervention does not address specific skills that the youth needs to learn and implement with regard to "healthy sexual boundaries." It also does not indicate the function that this behavior serves for this particular youth (e.g. attention seeking, control, etc), or how this was being addressed. The ITP regarding youth #999 included descriptions of interventions

	utilized to assist this youth in meeting goals. For example, "extensive history of aggressive…behavior…will work toward managing his anger in a more appropriate manner." The objectives then delineated specific workbooks and processing that is to occur with his assigned social worker, but did not outline specific skills that the youth needed to learn. Another weakness of this youth's case conceptualization and associated ITP was that it did not include information regarding this youth's mental health diagnoses and treatment with psychotropic medication. What was positive was that ODYS had recognized the staff weakness with regard to development of the ITP and proactively began a training and review program for staff. As stated in multiple areas of this document, Behavioral Health policy and procedure, including policy regarding treatment planning is pending. As stated previously: *Acceptable Integrated Treatment Plans must include measurable goals and objectives, with available targeted interventions to address each goal. Progress notes authored regarding the youth's treatment should refer to the youth's treatment goals and document the response (or lack thereof) to the prescribed interventions…Integrated Treatment Plans should be reviewed at each Interdisciplinary Treatment Team meeting scheduled for the youth, and must be authored and reviewed with the participation of the youth and their parent or guardian (if appropriate).* It was apparent that ODYS is attempting to improve their treatment planning services in order to achieve compliance with generally accepted practices. As this process evolves, quality assurance monitoring with corrective action (inclusive of additional staff education and training) will be necessary.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Finalize and implement policy and procedure regarding Integrated Treatment Plans. 2. Continue training for Behavioral Health Staff regarding development of Integrated Treatment Plans. 3. Ensure that Integrated Treatment Teams utilize the Integrated Treatment Plans as a road map for youth treatment and progress, and that the Integrated Treatment Plans are updated regularly as per policy and procedure pending review of revision. 4. Develop quality assurance monitoring tools that are both process (e.g. were the targeted interventions appropriate for a particular youth; were measurable goals and objectives identified; per a review of the youth's progress notes, did treatment provided to the youth follow the outline of the Integrated Treatment Plan) and outcome oriented (e.g. did the youth improve over the course of

	treatment per the Integrated Treatment Plan).
Sources of Information	• Staff interview • Review of provided documents • Review of youth records

III.B.9 Access to a QMHP. The State shall develop and implement policies, procedures and practices to ensure that youth who seek access to a qualified mental health professional are provided appropriate access in a timely manner.	
Compliance Rating	Substantial Compliance
Self Assessment	The facility self-assessment was provided orally. Increased mental health staffing was reported on the Progress Units in an effort to enhance youth access to mental health services. It was reported that daily "door checks" were occurring on Phase I. Youth on Phase II received a "door check" twice weekly. Policy and procedure regarding this requirement was pending.
Steps Taken to Assess Compliance	In response to a request for data regarding access to mental health services, the facility stated, "the presence of psychology offices on the units makes access to psychology staff simple and immediate. The use of forms and tracking systems to measure the response time would slow the process and increase the length of time between request and actually being seen. While forms are available to youth to make formal requests to be seen, and secure boxes are available on the units for these requests, the vase majority of contacts are by the schedule or by direct, face to face requests." In an effort show compliance with the above provision, seven examples of youth contact with psychology staff were provided (five of these were for female youth, two were for male youth). Five examples indicated that the youth requested to be seen and was seen immediately. Two of the examples were for individual sessions, both of which the youth declined to participate in the session beyond a few minutes. Supervisory staff indicated that currently, the practice is for psychology staff to indicate the time of the youth's request and the time that the assessment began. Per the document request and observation, secure mailboxes have been provided on the units for youth to request services without reliance upon direct care staff to communicate their request. Psychology or social work staff check these boxes daily. Youth interviewed during this monitoring tour were able to show the monitor the box within which to place their requests for services on their individual units. It is imperative that youth are able to independently access mental health care; as unfortunately, there may be situations where direct care staff could unintentionally or purposefully impede the youth's access to necessary mental health treatment with resultant negative outcomes. Given the Behavioral Health presence on the units, this is less of a concern, however, there are times (nights and weekends) where Behavioral Health staff are not immediately available, and youth must be able to make independent requests for services. One concern noted and communicated during the previous and current

	monitoring tours was access to mental health services for youth housed on the Progress unit. These youth were assigned to single cells where they remained the majority of the day. Youth on phase one of the program are in ambulatory restraints ("gators") when they are outside of their cells. There have been changes to the procedure for monitoring on the Progress Units, specifically, psychology and social work staff are required to make daily contact with youth on phase one which includes a mini mental status examination and encouraging youth to meet with and talk to the Behavioral Health staff. Per record review performed during the monitoring visit, documentation of these encounters was located. These reviews serve several purposes, to monitor youth housed in this area for decompensation, to identify youth requiring mental health intervention, and to ensure access to health care for those youth housed on that unit. It should be noted that late in the monitoring period, youth were allowed out of their cells on a daily basis for increasing amounts of time, which is positive. As this progresses, and youth are out of their cells for the majority of their waking hours, the need for daily mini mental status reviews will be reduced. Review of the documentation of these encounters revealed that in general they were brief (one to three minutes). Written documentation of these encounters included a mental status examination, which would be impossible to complete in this amount of time. This process must be codified in policy and procedure and reviewed via quality assurance. It should be noted that in general, youth interviewed in general population and on the girls mental health units believed that they had good access to their counselor and that mental health needs were addressed in a timely manner. Youth housed in the Progress Units were less satisfied with their mental health treatment and contact. Several youth interviewed indicated that they were not receiving regular individual therapy sessions. One youth filed a grievance to this effect. Please see the discussion in III.B.18 for additional information regarding this issue. Per a review of mental health staff schedules provided, mental health staff scheduling included both evening (until 8:00 p.m.) and weekend hours, allowing for better daily coverage of youth mental health needs. However, of the mental health staff, only the psychology supervisor was on-call 24 hours per day.
Recommendations	In order to maintain substantial compliance with this provision, the State must: 1. Revise policy and procedure to reflect requirements for daily mental health assessments for those youth housed on Phase I of the Progress unit.

	2. Revise policy and procedure to reflect requirements for twice weekly mental health assessments for those youth housed on Phase II of the Progress unit. 3. Develop quality assurance monitoring to ensure timeliness and adequacy of clinical contact with those youth housed on the Progress Unit. 4. Develop quality assurance monitoring to audit requests for mental health services inclusive of staff response time as well as timelines for completion of other mental health services as outlined by facility policy and procedure. 5. Ensure the youth's open access to mental health services
Sources of Information	• Review of provided documents • Youth interviews • Staff interviews

III.B.10 Mental Health Involvement in Housing and Placement Decisions. The State shall develop and implement a system for ensuring that significantly mentally ill youth who do not have the adaptive functioning to manage the activities of daily living within the general population are provided appropriate housing and supports to assist them in managing within the institutional setting.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally. ODYS staff indicated that they were screening youth referred to the Progress units in order to ensure appropriate referrals (e.g. that youth were not precluded due to a mental health condition). Facility staff reported increased ability to make referrals to specialized units (i.e. Life Skills, mental health unit).
Steps Taken to Assess Compliance	During the monitoring visit, it was discussed that policy and procedure was in the process of review and revision. Per staff interview, a new form has been developed that is completed by the assessing clinician for presentation to the treatment team, who then functions as the Behavioral Health Review Panel making the determination regarding housing decisions. With regard to placement on the Progress Units, the census on these units had increased slightly from the previous monitoring visit. Previously, there were 18 youth housed on the Progress units. This monitoring visit, there were a total of 21 youth (Phase I housed eight youth and Phase II housed 13 youth). In order for youth to enter the Progress Units, the referral process had continued. Staff are required to complete referral packets that must be presented facility administration for approval. Once placement is approved at the facility level, these admission packets must be approved by ODYS central office. For those youth with current mental health diagnoses or conditions, central office Behavioral Health staff are consulted. Unfortunately, no examples of this process were provided for off site review. As noted previously, policy and procedure is in the process of review, and this process will reportedly be included in the resultant policy and procedure. Following the submission of this draft report, some examples of the admission review documents for youth considered for admission to the Progress Units were provided for review. These assessments had improved and were more comprehensive. Observation and interview of a sample of youth currently housed on the Progress Units revealed cause for concern with regard to the screening process. For example, Youth #777 reported a history of multiple transitions between Phase 1 and Phase 2 of the Progress Units. He indicated that he was not currently prescribed psychotropic medications. In his presentation, he was distractible, exhibited rapid speech, loosening of associations, was irritable, and labile. Staff interviewed indicated that this youth does not appear to appropriately process information and does not follow directives. During the

	monitoring visit, it was recommended that this youth be considered for a psychiatric evaluation and consideration for transfer to the mental health unit. Information received following the visit indicated that the youth was considered for transfer; however, this ultimately was not performed. The rationale was as follows: *"Current Functioning: …recommended for promotion to Transition and continues to maintain stability and solid behavior on the Progress Unit. He is sitting for the official GED test all day today and so far is doing very well. Based on his improvements and stability, …earned a release date of 11/28/2012 contingent on successful completion of the Progress Unit program.* *While he continues to be a challenge with regards to medication and medication compliance, he is engaged in the process and has demonstrated an openness to continue a discussion of the issues. Conversely, his response to and engagement in psychotherapy with his clinical staff has become consistent, something to which he looks forward, and appears to have become a significant source of support and a catalyst for change and progress.* *With an approved release date so close, it is not at all clear that the (possible, but not certain) benefits of transfer to the MH unit would surpass the potential loss and harm that may result from a complete change not only in setting but also in the entire team and clinicians working with him. While the original notion of potential referral, and ultimate formal referral, were based on the emergence and recognition of his mental health issues, the nearness of his release date was not included in the deliberation and decision. Because he has not only been very stable for an extended period, but is in fact presenting as increasingly stable, the release date clearly becomes a matter of central importance.* *Likely Gains from Treatment: Following from the above, my discussions over the last 24 hours have led to a question of likely gain from transfer as compared to what might be gained from remaining at SJCF with promotion to the Transition Unit and continued intensive treatment within the already established relationships with his clinicians here. While the MH unit at IRJCF will provide a solid clinical team and all the benefits of the specialized unit, there is always a period of adjustment, transition and accommodation involved in the development of truly therapeutic relationships. I did not consider this factor adequately in the context of the November release date when I initially made the referral. It became more clear in and through the discussion…may be the most important issue to consider.* *Re-entry Planning: Finally, the matter of re-entry planning is a critical*

	one with all youths but I would venture to say that it is especially critical with [him]. With a significantly greater level of involvement with and knowledge of [him], the clinical team at SJCF is better prepared to make the connections and develop the mechanics for a smooth and successful transition to his community. We believe he will require a substantial network of support and treatment and the team at SJCF is in a better position to make that happen by virtue of the factors I identified above: degree of involvement with and knowledge of [him]. *As a result of these considerations, I am recommending at this time that we place this transfer on hold and continue our intensive work …on the Transition unit at SJCF. We do not believe it would be in his best interests to transition him further to a GP unit and would plan to continue working with him on Transition until his release. If he maintains his current level of stability I would recommend that we make no changes in placement and work towards the development and coordination of a solid re-entry plan. If he begins to struggle and/or begins to display signs of instability and regression, the team here with their extensive experience with him would be in a better position to assess his immediate needs and to respond appropriately. If he displays signs of decompensation, we have everything in place to effect a rapid transfer to the MH unit if needed."* The above represents a partial response to the consideration for transfer to the mental health units. The issue this is not addressed sufficiently is this youth's mental health diagnoses and the need for treatment with psychotropic medication to address his symptoms. It is recognized that this youth likely refused mental health treatment; however, given the information outlined below, it was apparent that mental health issues contributed to his behavior prior to referral, and were not addressed prior to his referral. There was no documentation indicating attempts to develop a therapeutic relationship with this youth in order to educate him with regard to his illness and increase the possibility of adherence. Rather, he was transferred to the Progress Units, where he experienced a long term stay, difficulty with progression through the phases, likely contributed to by unaddressed mental health issues. This illustrates the need for improved mental health assessment, diagnostics, development of a case formulation, and generation of a treatment plan to address the youth's identified issues that is individualized. This youth was referred for placement on the Progress Unit in February 2012, and apparently experienced significant difficulty with the program, resulting in an extended stay. A review of this youth's referral for placement revealed that this youth had a history of assaultive behavior and gang involvement. The Progress referral fact sheet indicated that this youth was not on the mental health caseload, but

	recommended, "evaluate for mental health caseload." Additional information included revealed that the OYAS performed 1.10.12 indicated the youth was moderate risk in the areas of "Substance/Mental Health." Per the ODYS unified case plan dated 2.2.12, this youth had mental health diagnoses including "Bipolar Disorder, not otherwise specified; Conduct Disorder; Cannabis Dependence; Alcohol Abuse; ADHD by history; Tourettes Syndrome; and Borderline Intellectual Functioning." A review of the treatment goals proposed by the case plan revealed that there were "no goals being addressed for this domain at this time" in the areas of substance abuse and mental health.. Per a psychological evaluations dated 3.29.10 performed at SJCF, this youth presented with behavioral observations including "rapid and pressured speech…difficult to understand…thoughts…concrete, were logical and coherent…minor attention problems…easily distracted…" Given the above, it was apparent that mental health issues were significant and not appropriately addressed prior to transfer to the Progress Unit and during the majority of his stay there. Nine examples of intake assessment and subsequent Behavioral Health Appraisal documents were reviewed. In the sample provided, all youth were referred for a Behavioral Health Appraisal at intake. Included in the Behavioral Health Appraisal was a recommendation for placement. All of the examples received were recommended for placement in the general population. While overall there were improvements noted in the quality of documentation, variability remained. This is an area that should be monitored via quality improvement. Some documents were completed; others were not. What was lacking in all documentation was a case conceptualization outlining the justification for specific diagnosis. At this stage, it is acknowledged that the case conceptualization would be brief, with further detail and refinement performed by the youth's mental health treatment provided upon assignment to a specific treatment provider.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Complete policy and procedure review. 2. Review the referral process for youth considered for placement on the Progress Units. Ensure that appropriate services have been considered and provided prior to referral. Determine specific mental health diagnoses that would be inappropriate for consideration (e.g. thought disorders; acute mental health exacerbations; developmental disabilities; etc.) 3. For those youth who require enhanced treatment following the

	initial placement determination, consider performing retrospective record review (e.g. QA) in order to improve assessment and placement process. 4. Begin quality assurance monitoring regarding intake and placement documentation and processes. 5. Indicate the method by which youth who are not referred for a Behavioral Health Appraisal are assessed for appropriate placement within the facility. 6. Improve documentation promulgated by the Behavioral Health Appraisal.
Sources of Information	• Staff interview • Review of provided documents • Review of youth records • Youth interview and observation

III.B.11 Staffing. The State shall staff, by contract or otherwise, the facilities with adequate numbers of psychiatrists, psychologists, social workers, and other mental health professionals qualified through training and practical experience to meet the mental health needs of youth residents, as determined by the acuity of those needs. Mental health care shall be integrated with other medical and mental health services and shall comport with generally accepted practices. The State shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to allow youth reasonable access to structured programming.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally, and indicated increased psychiatric resources. For additional information, please see the discussion in provision III.B.13 below.
Steps Taken to Assess Compliance	A review of the provided documents revealed a spreadsheet of all mental health positions. There were a total of 14 filled social work positions (including two supervisory positions). Of these, 11 were licensed. This represented increased vacancies since the previous report where there 18 filled social work positions. There were six vacant social worker positions. One of these positions was noted as vacant as of 3.11.12, others were noted as vacant as of later in the year 2012, with one vacancy noted as a "new position." There were a total of eight filled psychology positions (including one supervisor). Of these four were psychology assistants (unlicensed). Four were licensed psychology staff (inclusive of the psychology supervisor). There were two vacant psychology positions, one assistant and one psychologist. These positions were noted as vacant as of 3.11.12 and 9.9.12 respectively. There were two licensed psychiatric nurses. Other mental health staff positions included two occupational therapists, a transcription service, and the two facility psychiatrists. Schedules for psychology staff were provided for review. Per this document, psychology staff work a flex 80 hour schedule every two weeks. Regular hours are 8:00 am to 4:30 pm, and they are required to work one late night per week and one weekend per month in an effort to provide greater clinical coverage at the facility. The exception to this coverage is holidays, where per the schedule examples provided, no psychology staff is on duty. Per staff report, the psychology supervisor is on call after hours and holidays and will present to the facility as needed. In an effort to address clinical need on the Progress Units, mental health staff resources have been shifted. There are now three psychology staff assigned to these units, with plans for the youth to keep the same psychology staff as they progress through each phase, including transition. Additionally, there have been efforts to assign both a psychologist and social worker to each housing unit. These shifts were the initial phase of a larger plan verbalized by ODYS to create a

	behavioral health team in contrast to the previous silos inherent in having artificial divisions between the departments of social work and psychology. The revision process for policy and procedure was also a step toward this integration as per staff interview; staff from various disciplines were assigned to work groups in order to provide input into the policy and procedure documents. Per the previous monitoring report, the workload for psychology staff had increased due to vacancies in social work staff positions. It was opined by the monitor that once social work positions were filled, it would be advantageous to examine the current psychology staffing pattern and required psychology workload in order to objectively determine the need for additional staff. With the planned integration of departments and creation of a behavioral health team focus, this may be premature. The deficiencies in social work staffing have reemerged, as there are currently six vacancies as opposed to two vacancies at the time of the previous monitoring report. Per staff interviews and documentation provided during the previous monitoring period regarding support staff for psychiatry, the psychiatric nurse was carrying a large workload. According to the documents reviewed, the nurse provided the following support services to psychiatry: scheduling new and follow-up appointments; preparing medical records for review; providing dictated reports for review; updating the mental health database; attending team meetings and providing updates to the psychiatrist when he was unavailable to attend; responding to staff concerns and preparing assessment information for psychiatry; assisting with the notification of parents/guardians of any changes in the youth's mental health status or treatment; providing updates, changes, and concerns regarding youth to psychiatry; assisting in education of youth regarding mental health issues; monitoring, counseling, and reporting regarding medication compliance; and communicating day to day issues regarding psychiatric care to the health services administrator. This list of tasks was daunting, and physically impossible for one individual to complete, although the individual in this position was doing her best to manage the workload and did not complain. Approximately one month prior to this monitoring visit, a second psychiatric nurse had been hired. The two nurses worked collaboratively and were excited regarding their potential efforts with two staff. Currently, one nurse was assigned to the progress units and one nurse was assigned to all other housing units. Each nurse was assigned to a specific psychiatrist. There were examples in the provided documentation of the ongoing therapeutic activities in the intervening period since the last monitoring visit. For example, per the document review regarding youth mental

	health contacts: • Between 7.1.12 and 9.29.12 there were 1020 total mental health contacts with female youth. This included group, individual, and crisis intervention. • Between 7.1.12 and 9.30.12 there were a total of 2978 mental health contacts with male youth. This included group, individual, crisis intervention, and daily door checks on Progress Units. While these mental health units are an improvement from prior contact reports, there remain issues. For example, the number of youth attending a group session was noted to be excessive. This was noted more frequently with group activities led by social worker staff. For example, Core Modules provided 7.1.12 by social work staff included 16 male youth. "Anger, Aggression and Violence" group provided 9.1.12 included 11 male youth. This number of youth in a group interaction is not conducive to either learning or process. Behavioral health staff should determine the maximum amount of youth who may attend any one group therapy. Given the above information, there were a total of 3998 mental health contacts over a three month period. Unfortunately, the average daily census over this time period is not known, therefore it was not possible to calculate the number of mental health contacts per youth. In addition, the total number would have to be adjusted with the removal of the daily door checks provided on the Progress Unit, which artificially inflate this number (daily door checks are brief interactions designed to ensure that youth are not decompensating, and would not qualify as individual therapy). Interviews with staff revealed that ODYS had done a review of the number of mental health contacts youth on the Progress units received. In the month of January 2012, 41 youth received an average of 7.8 hours of mental health services. The average over the four months prior to the monitoring visit was reported as 16.56 hours of mental health services per month. This is a substantial increase. This information was provided via verbal report, actual data were not provided for review. During the monitoring visit, discussions with administrative staff revealed a focus on increasing group encounters, and holding staff accountable for group. With the current behavioral health staff, each clinician should be expected to engage in a minimum number of group therapy activities per week. Quality assurance monitoring to ensure that appropriate services with regard to both quantity (number of contact hours) and quality (with regard to fidelity to the model) are necessary.

	Given the serious staff shortages in social work and the need to ensure that current staff are able to provide the appropriate number of group and individual therapies to youth via a quality assurance process, this paragraph is in partial compliance.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Recruit and fill current vacancies 2. Determine the need for additional staff via workload indicators 3. Improve coordination between staff disciplines via the development of the behavioral health department. 4. Ensure coverage for staff during required trainings and other absences. 5. Ensure the creation of a unified behavioral health team. 6. Begin quality assurance to review both the quantity and quality of individual and group therapeutic interactions provided to youth.
Sources of Information	• Staff interview • Review of provided documents

III.B.12 Medication Notice. Before renewing a psychoactive medication prescription from a community provider or commencing the administration of a psychoactive medication to a youth, the State shall ensure that the youth and to the fullest extent practicable and appropriate, his or her parent or caregiver, are provided with information regarding the goals, risks, benefits and the potential side effects of the medication and given an explanation of the potential consequences of not treating with the medication, and that the youth has an opportunity to consent to such medication. A) Involuntary administration of psychotropic medications to juveniles shall comply with applicable federal and state laws and regulations. The DYS clinical director, in consultation with the DYS medical director, shall review and request with DYS Legal Services prior to the approval for involuntary administration.	
Compliance Rating	Partial Compliance
Self Assessment	The facility's oral self-assessment indicated that policy and procedure development remained pending. They also indicated a peer review/quality assurance process for informed consent; however, documentation of completed reviews was not received for review.
Steps Taken to Assess Compliance	Per the draft policy and procedure reviewed for this monitoring report entitled "Psychotropic Medication, Use and Management" education including "addressing the goals, risks, benefits, and potential side effects associated with any given medication is given to each youth and his or her parent or guardian… the prescribing physician provides an explanation of the potential consequences of not taking the medication and explains that the youth has an opportunity a consent or withhold consent to be treated…provides guidelines within which medical professionals may petition the court to authorize involuntary administration of psychotropic medication." A revised policy and procedure was provided for review and comments were given during the monitoring visit. Eleven examples of informed consent documentation were provided via the document request. These examples included a form entitled "Information about and consent for medications for youth with mental health diagnoses." These forms, competed by the youth, outlined what information the youth retained following their discussion with the psychiatrist regarding the prescribed medication. The form also allows for documentation by the psychiatrist of attempts to or successful contact with the youth's parent or guardian in order to review potential psychotropic medications and obtain parental consent. Additional information (i.e. medication information sheets) are reportedly provided to the youth and their parents via the psychiatric nurses for their review such that full disclosure of potential medication side effects is provided. Of the examples provided, all were signed by the psychiatrist. All examples were signed by the youth and included brief descriptions of side effect information retained by the youth following discussion with the psychiatrist. Of the examples where parental consent was required

	(i.e., youth were under the age of 18 years), all documents indicated that the parent consented to treatment with the medication following telephone contact with the psychiatrist. In an effort to determine compliance with policy and procedure as well as with generally accepted practices for informed consent, quality assurance monitoring is required. Per the facility self-assessment provided for the previous monitoring review, given the presence of the Administrative Psychiatrist, there were plans to begin peer review with regard to this and other psychiatric treatment issues in June 2012. Documentation of the peer review was not provided. Interviews with youth at the facility revealed that in general, youth were able to name their prescribed medication. Youth also had some knowledge regarding the potential side effects associated with their prescribed medication. This indicated that informed consent practices were occurring on some level with respect to treatment with psychotropic medications. Interviews with psychiatric nurses revealed that currently they are not providing group medication education. They reported performing individualized teaching for youth prescribed a new medication. They reported plans to develop a lesson plan and curriculum for group medication education, instituting this service with youth housed on the Progress Units. In an effort to expedite this process, investigation of commercially available educational materials is recommended. Per the document request, there were no court petitions for involuntary administration of psychotropic medications in the 90 days prior to this monitoring visit.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue and improve documentation regarding informed consent that is consistent with generally accepted practices and facility policy and procedure. 2. Finalize policy and procedure regarding informed consent in conjunction with other behavioral health policy. 3. Begin a peer review or quality assurance process for informed consent and other psychiatric documentation. 4. Ensure that medication information sheets currently available at the facility are provided to the youth and sent via mail to their parent or guardian. 5. Investigate commercially available materials regarding medication education geared toward adolescents.
Sources of Information	• Youth record review • Review of provided documents

	• Youth interview • Staff interview

III.B.13 Mental Health Medications. The State shall develop and implement policies, procedures and practices to ensure that psychoactive medications are prescribed, distributed and monitored properly and safely, and consistent with generally accepted practices. The State shall provide regular training to all health and mental health staff on current issues in psychopharmacological treatment, including information necessary to monitor for side effects and efficacy. The State shall issue and implement policies and procedures for the administration of appropriate tests (including, for example, blood tests, EKGs, and Abnormal Involuntary Movement Scale tests) to monitor the efficacy and any side effects of psychoactive medications in accordance with generally accepted professional standards. The State shall also: a) share medication compliance data with the psychiatrist and document the sharing of this information; b) not withhold the provision of psychostimulants to youth when such treatment is clinically warranted.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally. During the monitoring visit, the policy and procedure entitled "Psychotropic Medication, Use and Management Of" was reviewed with ODYS administrative staff and feedback provided.
Steps Taken to Assess Compliance	The review of this paragraph was limited as one facility psychiatrist was not available during the monitoring visit. As such, the physician was not interviewed and clinic was not observed. Approximately two weeks prior to this monitoring visit, a second psychiatrist began providing services at the facility on an emergency contract. During the visit, this psychiatrist's contact was approved and he will be providing an additional 20 hours of clinical services weekly. Per interviews, it was planned for this physician to focus his efforts on youth housed in the Progress Units, inclusive of participating in treatment team meetings. It should be noted that while observation of the facility psychiatrist is preferred, in this instance the current facility psychiatrist had been observed on two prior visits. In addition, the new contract psychiatrist had also been observed and interviewed during monitoring at another ODYS facility. As such, the subject matter expert was familiar with their work and work product. Previously, there was concern that given the paucity of available psychiatric treatment providers, there was no clinician available to cover for the current provider in his absence. While interviews and review of the self-assessment from previous monitoring visits it was stated that a psychiatrist from another DYS facility was available to cover psychiatric clinic, there was no documentation that another psychiatrist ever performed clinical consultation at Scioto. As a result of this, there was cause for concern that psychiatric treatment of some youth was delayed. The addition of a second psychiatric treatment provider should help to provide coverage and ensure availability of resources. The newly contracted psychiatrist is an adult psychiatrist with

	experience in the treatment of adolescent patients. This physician can appropriately evaluate and treat youth aged sixteen years and older. For younger youth, clinical supervision for a treating adult psychiatrist with a child and adolescent psychiatrist should be considered. As the ODYS administrative psychiatrist is a board certified child and adolescent psychiatrist, he can provide the necessary clinical consultation. Psychiatric documentation was received for eight youth. There was documentation with regard to psychiatric evaluation; documentation of ongoing medication management was not received. There was no psychiatric documentation available for review with regard to the request for specific laboratory examinations. Youth interviewed reported undergoing phlebotomy ostensibly for laboratory examinations associated with treatment with psychotropic medication. Medication compliance data was readily available and reportedly provided to the psychiatrist during clinic. Given the presence of the Administrative Psychiatrist, the facility must begin the peer review/quality assurance process for psychiatric treatment. During the previous monitoring visit, the administrative psychiatrist reported he was in the process of revising the laboratory matrix, which designated required laboratory examinations for youth prescribed particular psychotropic medications. This revision remained pending. It is necessary that this document is revised, as there are obvious omissions. For example, for youth prescribed antipsychotic medication, there was no requirement noted for abnormal involuntary movement monitoring. Abnormal Involuntary Movement monitoring must be performed regularly (quarterly) during treatment with antipsychotic medications. For youth prescribed the antipsychotic medication Seroquel there was no requirement for annual eye exams, which are required due to the increased risk of cataract formation with this medication. For Lithium there was no mention of the need for an annual 24-hour urine creatinine clearance due to the risk of kidney damage inherent in treatment with this medication. For these and other noted omissions, this document must be reviewed and edited. Given continuous advances in psychiatric treatment, this document should be reviewed and updated periodically to ensure compliance with generally accepted standards of care. Once the initial review is completed and the laboratory protocol is implemented, quality assurance monitoring to determine physician compliance with the requirements, their review of the laboratory results, and their use of this information in clinical decision-making will be necessary. From the records provided, it was determined via a review of the

	mental health caseload document and the medication sheet for each of the youth that at the time of this monitoring visit, 63 youth were prescribed medication by the psychiatrist. This was a similar result to the previous monitoring period where 71 youth were prescribed psychotropic medication. In the previous monitoring reports, inaccuracies in the tracking data for youth on the mental health caseload were discussed. Per the review of the data for this period, there were improvements. The dates of treatment plans, caseload assignments, medication start dates, medication dosage, compliance with psychotropic medications, and current diagnoses appeared to be updated. From a system perspective, it was difficult to look at trends of data (e.g. trends of prescribing, trends with regard to medication compliance, timeliness of psychiatric evaluation, regularity of medication management) as the data were supplied for each individual youth with no compilation provided. It would be useful to determine if the data management system can be adjusted to provide reporting of data points for groups of youth over a period of time. This could also allow some quality assurance monitoring and the identification of possible issues for further quality assurance studies. Given the manner of the data presentation, it was difficult to determine the timeliness of psychiatric treatment. Per a review of the psychiatric clinic schedule, it was apparent that clinic occurred once or twice weekly in the previous 90 days. It was not possible to determine the time period between the youth's admission to the facility and their referral for a psychiatric evaluation. Timelines must be addressed via policy and procedure, and they should be monitored via quality assurance. Another challenge with the data presentation was determining timeliness of psychiatry clinic follow up. In an effort to determine this, the clinic schedule was reviewed, in general, there was documentation that youth were seen monthly. There were two notable exceptions: Youth #444 was last seen in January 2012 and is currently prescribed stimulant medication; and Youth #555 was last seen in March 2012 and is currently prescribed stimulant medication and antidepressant medication. Generally accepted practices as well as draft facility policy and procedure require that youth treated with psychotropic medications are assessed by the psychiatrist at least monthly. This was another area where quality assurance monitoring may be beneficial. Once the new psychiatric provider begins to establish clinic, the facility will need to determine if the current clinical resources are adequate for the psychiatrists to provide clinical services, participate in treatment team meetings, for response to crisis situations, for provision of on-

	call/after hours consultations; and for the psychiatrist to function as an integral member of the treatment team. If necessary, the facility must investigate other avenues in order to address the paucity of psychiatric clinical services. These could include telemedicine; developing an association with a residency training program where residents or fellows (with appropriate clinical supervision) could provide services. With regard to other issues required per this provision, the Administrative Psychiatrist indicated during the previous monitoring visit that he was in the process of developing training for staff with regard to current issues in psychopharmacological treatment, including information necessary to monitor for side effects and efficacy. The development of this training was pending.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Update policy and procedure regarding behavioral health to include timelines for psychiatric services. 2. Finalize policy and procedure regarding psychotropic medication management. 3. Ensure that youth receive timely evaluation and appropriate medication management follow up. This is an area that would be amenable to quality improvement monitoring and review. 4. In order to determine the appropriate number of full time equivalent psychiatric clinicians required by the facility, consider workload indicators inclusive of all clinical responsibilities required of the physician (e.g. clinic, documentation, treatment team meetings, crisis response). 5. If necessary, investigate other avenues to increase psychiatry clinical resources at the facility (e.g. telemedicine, association with academic institutions, use of residents or fellows with appropriate supervision). 6. Ensure clinical coverage for the current psychiatric treatment provider. 7. Maintain the document regarding the current mental health caseload. Edits to this document may assist in quality assurance. 8. Begin the peer review/quality assurance monitoring for psychiatric treatment and documentation. This would include a review evaluation and diagnostics, of treatment planning for psychotropic medication, of target symptom identification for treatment with psychotropic medication, assessment for side effects with psychotropic medications, and the assessment of benefit from psychotropic medication. 9. Ensure that youth are receiving proper laboratory examinations and side effect monitoring commensurate with the psychotropic medication they are prescribed. This would require updating of the laboratory matrix and quality assurance monitoring. 10. Develop and implement training for staff with regard to current

	issues in psychopharmacological treatment, including information necessary to monitor for side effects and efficacy. Present this training curriculum to the monitor for review.
Sources of Information	• Staff interview • Treatment Team observation • Youth record review • Review of provided documents • Youth interview

III.B.14 Mental Health and Developmental Disability Training for Direct Care Staff. The State shall develop and implement strategies for providing direct care and other appropriate staff with training on mental health and developmental disabilities sufficient for staff to understand the behaviors and needs of youth residents in order to supervise them appropriately.	
Compliance Rating	Non- Compliance
Self Assessment	The facility self-assessment was provided orally. Staff indicated that every year, all staff receive 40 hours of inservice training, with an additional eight hours of "booster" sessions that are staff specific and tailored to meet the needs of the facility. Staff reported that in the upcoming year, it was planned that staff would receive a total of 16 hours of "booster" sessions with eight hours devoted to mental health topics.
Steps Taken to Assess Compliance	As stated in the previous report, the goal of this provision paragraph is to provide training to facility staff such that they have a working knowledge of the youth's challenges (both from a mental health and developmental perspective) and to provide them with strategies to assist in their daily supervisory tasks with the youth. Training for direct care staff is important as in the correctional setting; they function as the de facto parents of the youth in their care. As direct care staff are an integral part of the youth's treatment team, they should be aware that due to specific mental health diagnoses, youth may have special needs (i.e. a youth diagnosed with ADHD may not respond to you the first or even second time that you call his name because he is distracted by extraneous stimuli). They should also be aware of which youth are being treated with psychotropic medication and have a basic knowledge of the potential side effects of the medication so that they can monitor the youth in their care. Per the facility self-assessment provided for the previous monitoring report, the administrative psychiatrist was collaborating with the psychology supervisor to develop training for all staff to educate them on psychiatric medications, side effects, benefits and long term concerns. This training curriculum has yet to be provided to the monitor for review. There was documentation of mental health specific training provided to direct care staff as outlined below. Unfortunately, corresponding curriculum was not provided to the monitor for review. Additionally, per a review of the topics presented, it appears that this training would be an excellent resource for direct care staff, and it was unfortunate that only eight direct care staff were able to attend (eight attended each day). "Juvenile Offenders with Mental Health Disorders" was presented by Lisa Boesky, Ph.D., September 25 and 25, 2012. Reportedly, a third training session is planned in May 2013. Topics included: • Which Juvenile Offenders REALLY Have a Mental Health

	Disorder? • Your Role with Mentally Ill Juveniles • Where Are You on the MHAT Continuum? • Juveniles with Attention-Deficit/Hyperactivity Disorder (ADHD) • Juveniles with Conduct Disorder or Antisocial Personality Disorder • Juveniles with Depression or Dysthymic Disorder • Juveniles with Bipolar Disorder • Psychotropic Medication • Suicide: Which Juveniles Are At Risk of Dying • Anxiety and Juvenile Offenders • Juveniles with Posttraumatic Stress Disorder (PTSD) • More Than Just A Bump on the Head • Juveniles Who Act Bizarrely or Hear Voices • Communication and Collaboration (juvenile justice, mental health, medical, school) • Juveniles Who Cut or Carve Themselves to Feel Better • Key Role YOU Play with Juveniles Who Have Mental Health Disorders Reportedly, eight youth specialists (the majority of these working on Progress Units), three operations managers, and two unit managers attended this two day training. Evaluations completed by the participants revealed that 72.22% of the ratings were "excellent." Per staff interviews, there were plans to repeat this training in the spring of 2013. ODYS is commended for this training opportunity for staff. It was unfortunate that additional staff members were not able to participate. As there is an opportunity in spring of 2013, it is hoped that all staff will be able to attend. Given the large number of staff requiring specialized training regarding specific mental health and developmental disabilities, this provision will remain in noncompliance. Pre-service for new employees receive training in the following areas: • Adolescent Development (2hrs) • Mental Health (1.5hrs) • SBBMS (2hrs) • Cognitive Behavior Therapy (1.5hrs) • Sex Offender(1.5hrs) • Emergency Response- Suicide Prevention (7hrs) Current 8hr. in-service (booster) training covers the following areas: • Strengths Based Behavior Management System • Interdisciplinary Team • Group Process • CBT Skill Cards For additional information regarding training, please see the discussion

	regarding paragraph 15 below.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop an organized training schedule and training curriculum for facility staff that addresses the requirements of this provision and addresses the facility mental health programming initiatives. 2. Provide curriculum of newly developed training to the monitor for review. 3. Track staff compliance with training requirements and provide documentation to the monitor.
Sources of Information	• Review of provided documents • Staff interview

III.B.15 Staff Mental Health Training. The facilities shall train: a) all staff who directly interact with youth (e.g., JCOs , social workers, teachers, etc.) on: (i) basic mental health information (e.g., diagnosis, specific problematic behaviors, psychiatric medication, additional areas of concern) and recognition of signs and symptoms evidencing a response to trauma; and (ii) teenage development, strength-based treatment strategies, suicide, and for staff who work with female youth, female development; b) clinical staff on the prevalence, signs and symptoms of Post Traumatic Stress Disorder and other disorders associated with trauma.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally, and reviewed recent trainings conducted including the ITP process, case conceptualization, and "Juvenile Offenders with Mental Health Disorders."
Steps Taken to Assess Compliance	Per the document request, copies of any newly developed mental health training curriculum were requested and none were received. Documentation of training provided in the six months prior to the monitoring visit was requested. This documentation noted: 1. "Juvenile Offenders with Mental Health Disorders" was presented by Lisa Boesky, Ph.D., September 25 and 25, 2012. Reportedly, a third training session is planned in May 2013. Topics included: • Which Juvenile Offenders REALLY Have a Mental Health Disorder? • Your Role with Mentally Ill Juveniles • Where Are You on the MHAT Continuum? • Juveniles with Attention-Deficit/Hyperactivity Disorder (ADHD) • Juveniles with Conduct Disorder or Antisocial Personality Disorder • Juveniles with Depression or Dysthymic Disorder • Juveniles with Bipolar Disorder • Psychotropic Medication • Suicide: Which Juveniles Are At Risk of Dying • Anxiety and Juvenile Offenders • Juveniles with Posttraumatic Stress Disorder (PTSD) • More Than Just A Bump on the Head • Juveniles Who Act Bizarrely or Hear Voices • Communication and Collaboration (juvenile justice, mental health, medical, school) • Juveniles Who Cut or Carve Themselves to Feel Better • Key Role YOU Play with Juveniles Who Have Mental Health Disorders Reportedly, eight youth specialists (the majority of these working on Progress Units), three operations managers, and two unit managers attended this two day training. Evaluations completed by the participants revealed that 72.22% of the ratings were "excellent."

	2. Psychology training documentation revealed that nine staff attended an eight hour training on "family engagement." 3. Other training attended by psychology staff included, "CPR/FA/AED", "MIS CBTO", "Youth Supervision Rules of Conduct", "Safety and Security", "Child Abuse and Neglect", "Youth Grievance", "Emergency Response", "Blood borne Pathogens", "Ethics", "PREA", "General Work Rules", "Equal Employment Opportunity", "MYR 1st quarter", "Wellness", "MYR 2nd quarter", "Emergency Response Belt Review", and "Shield Review". 4. ITP training was provided to behavioral health staff by ODYS central office staff. 5. ITP training and case formulation training was provided to behavioral health staff by Andrea Weisman, Ph.D. Unfortunately, training curriculum was not provided for review for any of the above noted trainings. Attendance was only available for those trainings where it was noted above. Given the confirmed attendance, there were staff of all disciplines who have not received training. Per a review of the presented topics, it appeared that the two day training via Dr. Boesky would be an excellent resource for youth specialists, and as such, it was unfortunate that only eight direct care staff had the ability to attend. Per the review of the training topics above, they did not include those topics required by the agreement. However, the State invested considerable time and resources in training that is needed to fully comply with the Stipulation. Previous monitoring reports have indicated, *"the facility self-assessment included, 'all staffs [sic] have been trained on BHS [Behavioral Health Services] policies and procedures. Staff receive a minimum of 40 hours of in-service yearly. In addition, ODYS brings in outside experts to train frontline staff as well.' The self-assessment then discussed draining performed by Dr. Lisa Boesky in August 2011, with plans for an additional two-day training provided by Dr. Boesky in May 2012. The self-assessment also indicated, 'staff have been trained extensively in CBT, motivational interviewing and strength based approaches.' No new documentation of completed training with regard to these topics was provided for the current monitoring period. Additionally, ODYS is currently in the process of a significant review and revision of behavioral health policy* and procedure, which would require review/refresher training for staff." The development of an organized, mandatory training schedule was a recommendation from the previous monitoring visits. It is absolutely necessary to develop and implement a training schedule for all staff providing care for youth with regard to mental health issues. This training must also address staff recognition of and response to the signs and symptoms of a serious mental illness in evolution as well as the

	specific training topics required by the agreement. The training schedule must be reasonable and address specific topics to ensure that staff are able to implement the facility mental health program. While training is important, the facility must be able to maintain sufficient staff onsite to ensure that treatment and security services are available. The oral self-assessment indicated a more proactive approach to providing training was occurring, and this is positive, however, both curriculum and spreadsheets indicating completion must be provided to the monitor.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop an organized training schedule and training curriculum for facility staff that addresses the requirements of this provision and addresses the facility mental health programming initiatives. Provide the curriculum for behavioral health training topics and spreadsheets regarding attendance to the monitor for review. 2. Consider offering multiple trainings for each topic so that staff can schedule trainings while ensuring that their regular job duties are addressed. 3. Track staff attendance and compliance with training requirements.
Sources of Information	• Review of provided documents. • Staff interviews.

III.B.16 Suicide Prevention. The State shall review and, as appropriate, revise current suicide prevention practices to ensure that suicide preventions and interventions are implemented consistently and appropriately, consistent with generally accepted professional standards of care.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self assessment was provided orally and indicated that the draft policy and procedure was reviewed by Lindsay Hayes, and comments were integrated into the draft policy and procedure. The completed document remained pending at the time of this monitoring visit.
Steps Taken to Assess Compliance	As noted above, staff reported that existing policy and procedure was submitted to Lindsay Hayes for review, and his comments had been incorporated into the draft document. The current draft was not submitted for review this monitoring period. The following information was provided for the previous monitoring review, and will be included here for comparison when the revised policy is completed. *"The policy and procedure entitled "Suicide Prevention and Response" revised October 3, 2011 was provided for review. Specific issues identified with this policy include:* *1. Procedures* *a. Screening and Assessment* *i. Reception - There is no designated time within which the Risk Assessment Interview must be completed (as attachments were not provided with the policy received, it was not possible to review the Risk Assessment Interview document).* *ii. Transfer – There was no mention of the assessment or watch precautions to be provided to youth on watch status during or following a facility transfer. There is a requirement for the "immediate" completion of a Risk Assessment Interview following positive responses to questions concerning suicide ideation and self-injurious behavior during the transfer process. The time limit for the completion of this assessment was not indicated.* *b. Communication* *i. "Psychology staff are required to review psychology file information within five days of a youth's admission to a facility in order to identify possible areas of concern regarding mental status, suicide or self injury and the need for any follow up services." The policy does not designate where this review is to be*

	documented, nor does it indicate if this review is for all youth admitted or only for those youth who have positive responses to the intake health screen. *c. Precautionary Status* *i. This section of the policy indicates that youth placed on precautionary status must have a Risk Assessment Interview within four hours. This is the first mention of a time frame within which this assessment must be completed.* *ii. Youth placed on "watch" and who are "assessed as being at the highest risk for suicide…engaged in critical suicide attempts" are required to have "constant visual monitoring within close proximity (i.e closer than 15 feet)…line of sight shall be unencumbered." With these requirements, the staff to youth ratio is required to be "not greater than one staff to three youth. Where an adjustment pod exists the rations shall be not greater than one staff to six youth." These ratios do not allow for close monitoring of youth. For youth who are actively suicidal, one to one monitoring is required. The policy does not allow for this level of monitoring except in the case of "youth designated as making a critical suicide attempt." The level of monitoring should be determined clinically, given the results of behavioral health assessments. Regardless of a critical suicide attempt, if youth are at serious risk, there must be the ability to access one to one supervision.* *iii. With regard to "observation" status, there is no staff to youth ratio designated.* *iv. With regard to "behavioral" status, there is no staff to youth ratio designated.* *d. Additional comments: The policy does not designate the process by which psychiatrist is notified of a youth requiring watch status. Currently, per the document request, this is performed informally via email; however, it must be codified in policy."* The agreement requires that ODYS demonstrate that interventions are implemented consistently and appropriately. In order for ODYS to ensure this, quality assurance data based on policy and procedure would be required. Per review of current policy, there is a requirement for monitoring "ongoing reviews shall be conducted by the designated Interdisciplinary team on a quarterly basis as part of the Departments

	Continuous Quality Improvement Process." Per the document request for this monitoring period, "any reviews or quality assurance data regarding suicide precautions" were requested. The response received indicated, "there is QA built into the monitoring log form…any discrepancies are to be noted and reported. Administration is also required to review monitoring logs when making round…to units…the OA and UMA will review random monitoring logs as a policy…but there is not a form or formal requirement attached to this process." In the previous three months, there were a total of five youth placed on suicide watch, and as such, there were youth records that could have been reviewed to assess compliance with policy. This would include process reviews, outcome reviews, and a review of data trends and analysis in order to determine compliance with policy, the need for individual corrective action, and the identification of systems issues affecting policy implementation. Based on the existing policy and procedure, partial compliance will be assigned.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review and revise current policy to address timelines and ensure appropriate ratios for youth supervision. 2. Perform quality assurance monitoring to ensure compliance with policy and procedure as well as the need for corrective action (see III.B.18 for details).
Sources of Information	• Review of provided documents. • Staff interview. • Youth interview.

III.B.17 Transition Planning. The State shall ensure that staff create transition plans for youth leaving the facilities, consistent with generally accepted professional standards of care.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	In response to a document request for transition plans for ten youth (five of whom were prescribed psychotropic medication) discharged from the facility, the monitor was provided with the "Regional Accountability and Community Engagement Report" completed by the youth's parole officer, not the youth's treatment provider at the facility. Transition planning must start at the time of admission, and plans must be created by the current treatment provider in order to inform the community parole officer and other community providers of the youth's needs. Nine examples of the facility generated "medical release summary" were reviewed. This document listed the youth's diagnoses, medication and dosages. It also included the need for follow up psychiatric treatment. Specific referrals (e.g. clinic name, phone number) were not included on this document. There was one complete set of documents (i.e. a "Regional Accountability and Community Engagement Report" and "Medical Release Summary" for the same youth). Per these documents, Youth #333 had a history of mental health diagnoses, and was prescribed psychotropic medication. Specific referral information was included on the summary with regard to gastroenterology clinic,, but not for psychiatry clinic. The "Regional Accountability and Community Engagement Report" indicated that this youth had a three day supply of medication provided to her at discharge, with a thirty day supply of medication mailed to her. There was also documentation of an initial appointment with a mental health treatment provider. Furthermore, the "Medical Release Summary" indicated that this youth gave birth approximately one month prior to her admission to the facility. There was no note of the infant included in the "Regional Accountability and Community Engagement Report." Unfortunately, the transitional planning documentation was not included with these examples; therefore, other information regarding the infant, the youth's need for parenting skills, or other services was not available. In previous reviews, psychological services summary documents were provided for review that included a review of the youth's presenting problem; history of suicidal ideation, suicide attempts, and self injurious behavior; diagnostic impressions at intake; diagnosis history; five axis diagnosis; overall progress in treatment; goals; services provided; current medications; clients response to treatment; continuity of care/referral information; and aftercare options. Per the prior

	monitoring report, *"the completeness of documentation was variable between documents, and would be amenable to quality assurance monitoring and corrective action. The documents were inconsistent in terms of specific discharge plans and lacked definitive plans with regard to referrals, support services, and parent education. Most recommendations were stated as "most likely" or "will probably." The transition plan recommendations should include concrete discharge plans for the youth and as such, should define a plan of action that the youth and their parent/guardian can follow. Again, there was marked variability in these documents…For youth prescribed psychotropic medication; follow up recommendations did not include the identification of clinical resources for follow up. There was no mention of a designated medical provider to perform continued monitoring of the prescribed medications on an outpatient basis. These summary documents may not be reflective of the discharge and transition planning activities performed by the behavioral health staff…In reviewing existing policies related to transition planning, there was ambiguity regarding who the responsible party is for creating and implementing transition plans prior to release, particularly with regard to mental health follow-up. For example, in the policy entitled "Transition Planning for Age 21 Youth," the policy clearly states that the juvenile parole officer "shall provide each youth with a comprehensive list of community based resources specific to the youth's needs." This is to include "treatment links/mental health services." With regard to youth under age 21, there was no specific policy included in the documents for review regarding transition planning; rather this is incorporated into the policy entitled, "Behavioral Health Services." Per this policy, "youth in need of continued mental health services shall receive, as part of their re-entry plans, referrals for continued treatment. Efforts shall be made to connect the youth and family directly with the community provider." The policy does not denote which staff are responsible for this task. It will be necessary to determine what tasks need to be completed as part of transition planning and who the responsible part will be in order to ensure youth leave the facility with appropriate scheduled follow-up services. As stated in the discussion for many of the paragraphs in this report, ODYS was in the process of a review of policy and procedure that should address these challenges."* Per ODYS staff, policy and procedure revision continued, and completion/implementation of policy and procedure was pending. Transition planning for all youth should include referral to appropriate community resources. For mentally ill youth this is especially important, and must include linkages to community mental health clinics and a scheduled appointment such that youth can access follow up care without an interruption in medication treatment. The documentation provided for review did not include designated follow-up appointments for care following transition into the community. Due to the state of

	outpatient mental health services, appointments may take more than 30 days advanced notice to schedule. As youth are released with 30 days of medications, it is vital that they have appointments scheduled in advance to ensure continuity of care.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revise Behavioral Health Policy and Procedure to reflect the requirements of this provision. This should include delineating the responsible party for transition planning to include mental health aftercare appointments. 2. Begin transition planning at the time of admission to ensure that youth receive appropriate services at the time of discharge. This must include involvement of the youth's parent or guardian. 3. Document transition activities in the transition/discharge documents. 4. Begin quality assurance monitoring of transition planning.
Sources of Information	• Review of provided documents. • Staff interview

III.B.18 Oversight of Mental Health Services. The facilities shall ensure that youth receive the care they need by developing and implementing an adequate mental health Quality Assurance/Improvement Program; annually assessing the overall efficacy of the staffing, treatments and interventions used at the facilities; and as appropriate revising such staffing, treatments and interventions.	
Compliance Rating	Non-Compliance
Self Assessment	The facility self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	As noted in the previous monitoring report, the facility had developed policy and procedure regarding Quality Assurance/Improvement. This policy, with an effective date of January 1, 2011 entitled "Behavioral Health Quality Assurance/Quality Improvement" outlined the process for clinical supervision and audits of clinical documentation. As noted above in this monitoring report, there was a recent effort undertaken by ODYS administration to perform a global review and rewrite of policy and procedure regarding behavioral health services. The goal of this process was to streamline policy and to promote the integration of mental health services (psychiatry, psychology, and social work) into one behavioral health program. In order to achieve this goal, ODYS designated work groups to review and edit policy and procedure. The revised policies, including policy and procedure regarding quality assurance remain pending. Quality assurance audits with respect to process should be developed to address specific policy and procedure requirements. Quality assurance audits were provided for review. These were performed via the clinical supervision sessions. The forms included sections headed "caseload review", "quality review", and "professional review." The majority of the forms contained blank spaces, and did not reflect a systematic review of clinical quality or documentation. As data were not presented in a collated format, it was not possible to determine trends, or the need for corrective action with regard to one particular clinician, one particular housing unit, or if there were issues requiring attention from a systems perspective. It was noted on each individual audit that there were either compliments for the clinician's work or specific issues reviewed with the clinician under review; however documentation provided revealed that no formal corrective action had been instituted from quality assurance monitoring in the 90 days prior to the monitoring visit. Issues with this type of quality assurance monitoring can be

	illustrated by the case of Youth #222. This youth filed a grievance indicating that he had not been receiving individual mental health counseling sessions. The grievance was dismissed as having "no merit" as the youth was receiving daily door checks via psychology. Daily door checks are not a substitute for individual therapy. A review of this youth's mental health documentation revealed no individual therapy sessions between 7.1.12 and 7.23.12. Regular quality assurance could monitor for lapses in treatment in addition to the clinical quality of documentation. One behavioral health peer review narrative was provided for review. Unfortunately, this documentation did not include the comments of the peers. Additional information provided with this example indicated, "the new peer review process outlined in current policy has not yet been implemented system wide." As noted above, the review of available documentation regarding quality assurance revealed a disjointed process that did not lend itself to a cogent review of the system or services provided. Additionally, at the time of this monitoring tour, there was no formal quality assurance monitoring occurring with respect to the psychiatric physician. It will be necessary that ODYS quality assurance monitoring review four specific areas, include a review/analysis of the resulting data, and corrective action as needed. Additionally, a predetermined percentage of all available records should be reviewed (e.g. 10%). 1. Process measures- this type of quality assurance would determine if behavioral health services are provided in keeping with implemented policy and procedure (e.g. were evaluations performed within a specific timeline; were laboratory examinations required via laboratory parameters ordered, reviewed and addressed; did youth receive the mental health services as directed by their treatment plan; were requests for mental health services performed in a timely manner; were psychiatric evaluations performed in a timely manner, etc.). For process measures regarding psychiatric evaluation and treatment, monitoring should be done via a medical model in concert with quality assurance monitoring performed for medical services. 2. Outcome measures- this type of quality assurance would determine if behavioral health services provided were of benefit to the youth. Specifically, did they result in a reduction of youth symptoms and improvement in youth functioning? This could be determined via review of youth on youth violence statistics, youth aggression statistics, and the use of segregation. Additionally, pre and post testing

	measures could be utilized (e.g. reduction in the scores on depression scales). It is recognized that improvements in the indices discussed above would be multifactorial and not solely the result of behavioral health services. Other outcome measures could include youth satisfaction surveys. 3. Peer review/Treatment integrity- this type of quality assurance would include a critical review of behavioral health services provided via a peer-review process (e.g. psychiatrists would periodically review each other's work and provide feedback). Additionally, group therapeutic process could be observed with feedback provided to the clinician or youth specialist leading group in order to ensure adherence to the model and provide opportunities for coaching and improvement of the provided services. 4. Selected studies – If a specific issue is suspected, or specific difficulties are observed with one particular unit, specific quality assurance studies could be performed with a critical analysis of the data in order to determine the need to adjust processes or treatments in order to improve efficacy. 5. Corrective action – Any comprehensive quality assurance process must include both the synthesis and review of collected data on a regular basis. Data must be collected on a continuous basis and reviewed so that issues can be addressed in a timely manner. These issues may include challenges with the practice and documentation attributed to a specific staff member or they may identify systems issues. Issues that are identified must be addressed via a corrective action plan (e.g. staff training, staff supervision, policy/procedure review).
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Complete the revision of behavioral health policy and procedure. 2. Develop quality assurance monitoring based on policy and procedure. This would include process measures, outcome measures, peer review/treatment integrity, and data analysis/corrective action.
Sources of Information	• Staff Interview. • Review of the provided documents.

G.1 Progress Notes. The Facilities shall promulgate and implement a policy requiring that all health professionals be required to create and use progress notes to document, on a regular basis, interactions and each assessment of youth with mental/behavioral health or substance abuse needs. In particular, progress notes shall: a.) In the assessment, address the efficacy of interventions, currently presenting problems, and the available options to address those problems; and b.) Provide thorough documentation of all crisis interventions or, if not thoroughly documented in the progress notes, provide a reference to alert staff to another document in the youth's file containing the details of the crisis intervention.	
Compliance Rating	Partial Compliance
Self Assessment	The facility self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	Per interviews with mental health staff from both the facility and ODYS administration, a review and revision of mental health policy and procedure is in progress. Mental health documentation reviewed for the preparation of this monitoring report, while improved over previous reviews, continued to reveal deficiencies in clinical documentation. Mental health staff were authoring case conceptualizations; however, these were not located in all records reviewed on site. Documents reviewed revealed that overall, the case conceptualizations were in need of improvement. For example, the case conceptualization regarding Youth #111 adequately described this youth's home life and gang involvement. Treatment goals were identified to address challenges in these areas. Goals were not measurable, for example, "I will make a plan to develop new friends in the community and practice my positive social skills in ODYS." Treatment objectives included a time limit within which the objective was to be completed, "I will figure out what makes a good friend as evidenced by completing workbook…and process it with my social worker by 9.30.12." The youth's progress toward the identified objective was documented. The treatment plan would have been strengthened by the addition of measurable goals and objectives with regard to teaching positive social skills. In addition, this youth also had substance abuse and mental health diagnoses and was prescribed psychotropic medication. The case conceptualization did not review the youth's mental health history, nor did it review the symptoms the youth was experiencing in order to justify the diagnoses. A review of the youth's treatment plan revealed no treatment goals targeting substance abuse, the mental health diagnosis, or psychotropic medication. Specifically, mental health assessments did not routinely evidence adequate case conceptualization information required to develop a treatment plan addressing the youth's needs. The documentation was

	especially weak with regard to mental health and substance abuse diagnoses. There was wide variability in the quality of progress notes documenting treatment. There were noted improvements in isolated instances, as discussed in the paragraphs regarding mental health services above. As discussed during the monitoring visit, this was an area that may be amenable to quality assurance monitoring. Examples of documentation regarding crisis intervention were limited; however, those reviewed revealed improvements with regard to timeliness of assessment. Record review revealed that in general, documentation was completed within 24 hours. In addition, when follow up visits were recommended, documentation was located. In future monitoring visits, additional examples of crisis intervention documentation will be requested.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that case formulations are complete, outlining criteria for specific diagnoses and indicating specific youth risk factors for ongoing challenges. 2. Ensure that treatment plans include measurable goals/objectives with targeted interventions included to address each treatment goal and that progress notes reflect interventions aimed at addressing specific treatment goals. 3. Complete the planned review and revision of policy and procedure.
Sources of Information	• Mental health records • Interviews with ODYS administrative staff • Interviews with facility mental health staff

G.2 Accessibility of Relevant Information. The Facilities shall ensure that youth records are organized in a manner providing treatment teams prompt access to relevant, complete, and accurate documentation regarding the youth's status.	
Compliance Rating	Non-Compliance
Self Assessment	The facility self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	Currently, the record-keeping program at the facility is cumbersome. There are multiple databases where information is stored, making access to information challenging. For example, the integrated progress notes reviewed contained information that was generated by psychiatry and psychology, there was no social work information included. The medical record included psychiatric documentation (evaluations and medication management progress notes), but did not include other mental health documentation. Given the multiple locations where information is stored, the information gathering process is laborious, therefore increasing the possibility of error. Per interviews with ODYS administration, there are plans to implement an integrated electronic health record, but at the time of this monitoring visit, this project remained in the planning stages. Pending this improvement, mental health staff of all disciplines are hampered by the current documentation system. Regardless, as stated in G1 above, per the review of youth records and mental health documentation available for off site review, there was considerable variability in the quality of documentation regarding mental health treatment. This is an area that would be amenable to quality assurance (with associated corrective action) and peer review.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that all mental health staff, including psychiatrists, have access to relevant, complete and accurate documentation regarding the youth's mental health status and treatment. 2. Continue and expand quality assurance monitoring of mental health documentation. This would include a review of a percentage of mental health records along with corrective action plans as needed.
Sources of Information	• Mental health records • Interviews with ODYS and facility mental health staff • Medical records

MEDICAL SERVICES

III.C.1 General. The facilities shall ensure that the individuals they serve receive routine, preventive, and emergency medical and dental care consistent with current, generally accepted professional standards. The facilities shall ensure that individuals with health problems are identified, assessed, diagnosed, and treated consistent with current, generally accepted professional standards of care.	
Compliance Rating	Partial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) did not conduct a self-assessment for the level of medical and dental care provided at SJCF during this assessment period. However, there has been significant improvement in their quality assurance processes, which in essence completes the task of self-assessment for the purpose of this report.
Steps Taken to Assess Compliance	An onsite visit was conducted at the Scioto Juvenile Correctional Facility on October 16-18, 2012. It was this monitor's second visit to the facility. All previous reviews of health information and other related documents had been conducted off site from records provided by ODYS. Some of the living units were undergoing repairs secondary to storm damage. Available living units were visited and procedural operations and access related to health care observed. Youth were interviewed on the units as to how to access sick call and if they had any complaints regarding their medical care. The food service area was toured and the medication room located there observed. The satellite clinics for Buckeye had not been completed. The rooms had been identified and converted from existing cells. The toilet/sink combinations were still remained in the room with an exam table. There was not an appropriate sink or adequate medical equipment to make it suitable as an exam room or to use to dispense medications. The main clinic was still found to be adequate, with appropriate space, medical supplies and equipment for medical and dental care of the youth. Documentation from January 12, 2012 was provided by Dr. John Bradley, ODYS Medical Director stating completion of the annual review and revision of each policy, procedure and program in the health care delivery system with an attached list of said policies and standard operating procedures. A review of eight youth health records housed at the Scioto Facility was conducted. This included any Youth Injury and Assessment Forms present in the chart. The health record review included assessing completeness of the Problem List, the presence and timeliness of the Nursing Intake Screening, Mental Health Screening, Physical Exam, Dental Exam, Dental Treatment, Oral Hygiene Instruction and Growth Chart. Admission labs were checked for completion and results within 20 days; STD screening for Gonorrhea and Chlamydia; Chronic Care and Specialty Care Consult

	documentation; Transfer of Health Records; Immunizations and Tuberculosis Screening; Medication Administration Records; Mental Health Documentation; Progress Notes and Physician Orders were checked in each health record. Since the last visit, the health records now contain the original health request completed by the youth, which are addressed by medical staff in the progress notes. All records documented timely completion of intake assessments such as nurse screenings health appraisals and physical examinations all on the same day of admission. Growth Charts were present for all youth. There was documentation of admission labs being drawn with results available all within a week. STD screening results were documented in all records. Immunization records were up to date on all records reviewed. HPV vaccine is now being administered to all youth, male and females, as available. There is a back order on the HPV vaccine through the Federal Vaccines for Children Program. I reviewed the facility's vaccine accountability order documentation. Youth had already been administered influenza vaccine for the current flu season. All youth received tuberculosis screening with documented results. Dental examinations were completed within a week of admission with instruction given on oral hygiene. Dental treatment was provided as a result of the dental examination or as a result of a Health Request. Youth are being recalled every 6 months for dental care. All youth allergies were noted in their health record. Medication administration records and physician orders were also reviewed for accuracy and medication compliance. There was documentation of three optometry consults for youth to receive glasses. Youth complaining of headaches received a neurology consult and CT scan. Diabetic youth appropriately received ophthalmology, endocrine and podiatry consults. Two of the eight youth records reviewed had with chronic medical conditions (diabetes). Both received appropriate assessments and treatment plans. There were only five youth at the facility with chronic medical diagnoses, including the two reviewed. Six of the eight youth records reviewed had at least one mental health diagnosis. All mental health diagnoses as well as medical diagnoses were listed on the problem list. This is a significant improvement since the last review. Medical services for the 10 females at the facility were discussed with their provider, Dr. Stein. He stated most of the girls have already had PAP smears and refuse the pelvic exam. The American College of Obstetrics and Gynecology (ACOG) no longer recommends PAP smears in females less than 21 years of age. All females are screened for Gonorrhea and Chlamydia using a urine test. There were no pregnant girls at the facility, but services are either provided through their designated Hospital (Grady) or girls are transported back to their community Obstetrician for

	continued care. When nurses made seclusion checks, they were documented in the progress notes. Logs were posted on the unit doors. Some youth identified through review of the medical records spent several days in seclusion. Progress notes simply state "seclusion check" without details of the youth's health status. A full progress note is needed in SOAP format. Youth are spending a significant amount of time in seclusion on the Progress Unit, therefore making it even more important to document the details of their health status. There was one youth with 3 days documented since his arrival on 6/14/12. One youth had 24 days of seclusion checks documented between February and October 2012. Another had 51days in seclusion between January and the time of the visit. A fourth youth had 69 days of documented seclusion checks within a year. Many of the days in seclusion ran in continuous blocks. At least half of the medical records reviewed had documentation of youth having been secluded. Documentation on the Youth injury and Assessment Reports were reviewed for those included in the eight health records. There has been overall improvement in the documentation provided by nursing staff for youth assessed for injuries. There are still some individual nurses that are not adequately documenting these assessments. This was discussed with the Nurse Manager, Ms. Vickie Donohue, who was already aware through the continuous quality improvement (CQI) review process. These individuals have been placed on a performance improvement plans. Internal (CQI) Quality Assurance documents were reviewed that were provided by ODYS which included several audit instruments. The QA instruments and processes have been revised since the last visit. The Nurse Manager is now involving more staff nurses in the process and the documents have been formatted differently for easier use. This is a good idea and helps staff to understand and complete the process better. Chronic Care audits are now conducted quarterly due to the small number of youth with chronic medical conditions. Medication Administration Record Continuous Quality Improvement (CQI) documents for April 10, 2012 and August 3, 2012 was reviewed. Between April and August there was improvement from 60% to 100% on the compliance indicator of medication frequency, doses, route, start and stop date documented. Improvements from 60% to 100% were also shown in 3 other areas of medication compliance indicators. The CQI Problem List review showed significant compliance with documentation of all chronic medical conditions, including mental health diagnoses. This is consistent with the improvement I noted on this visit compared to the previous one. There still needs to be improvement on documenting acute medical conditions on the problem list, as noted in the CQI report. Vital signs at the time of encounter were reviewed on June 5, 2012 and August

	7, 2012. The documentation of vital signs CQI audit showed improvement from 85% to 95%. The CQI Processing of Specialty Consults was reviewed from June 2012, September 6, 2012 and October 9, 2012. The initial June review identified the need for improvement In all areas, except physician orders being written for consultation and youth being seen by the physician at the next clinic visit. The September audit showed improvement to 90% in all areas but one. The October CQI review showed 100% compliance in 80% of the compliance indicators. CQI documents for completion of the Youth Injury Assessment Form (YIAF) were reviewed from June 5, 2012, July 9, 2012 and October 5, 2012 and showed improvement of youth on the Progress Unit being brought to the exam room for evaluation. The Nurse Manager, also through the CQI process was able to identify certain staff not properly conducting assessments, as previously noted. What is most important is the process and that medical staff are conducting self assessments and developing corrective action plans based on their findings in order to continuously improve the quality of health care. During this site visit, I met with Dr. John Brady, Medical Director and Pamela Robbins, Director of Nursing along with Scioto Nurse Manager, Vickie Donohue to discuss all medical findings.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Complete satellite clinic and medication room on Buckeye Units for adequate injury assessments of youth and medication administration on the unit. 2. Limit time of youth in seclusion and improve documentation of health status during segregation. 3. Continue to improve Quality Assurance (QA) activities by considering a review at least annually by a source external to ODYS Health Services. ODYS should also consider expansion of the QA process to include some additional quality indicators. Conduct Quality Assurance Program as outlined in the National Commission on Correctional Health Care Juvenile Health Standards. This would satisfy the need for a self assessment.
Sources of Information	• Site visit tour; Review of eight youth health records: ID # 217938, 217241, 217365, 217718, 215927, 218016, 218076, and 218098; CQI Documentation as outlined above.

III.C.2 Health Records. The State shall develop and implement policies, procedures and practices to ensure that, consistent with State and federal law, at a minimum, the juvenile courts in the State, all juvenile detention facilities and all placement settings from which youth are committed shall timely forward to Scioto, or to the facility of placement (if the records arrive after the youth has been placed), all pertinent youth records regarding medical and mental health care. The facilities shall develop and implement policies, procedures and practices to ensure that health care staff, including mental health care staff, have access to documents that are relevant to the care and treatment of the youth.	
Compliance Rating	Partial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) did not conduct a self-assessment for the level of medical and dental care provided at SJCF during this assessment period. However the health records are being reviewed as a part of the CQI process.
Steps Taken to Assess Compliance	Review of eight youth health records. There were no new Health Policies and Procedures or Standard Operating Procedures (SOP) completed by ODYS since the last visit. All health records reviewed contained some health information transferred from the county probation offices or other facilities. I still have a concern that the offense data contained within the Disposition Investigative Report is included in some of the health records along with the medical information on the youth. The offense information is irrelevant to the provision of the youth's health care and should not be included in the health record. The health record is still fragmented due to the psychological and counseling notes being housed separately on the housing units. However, two weeks prior to this visit, an RFP was awarded to eClinical Works through the Ohio Department of Administrative Services and the Office of Information Technology (OIT) for implementation of an electronic health record (EHR). I reviewed the Adult Department of Rehabilitation and Correction (DRC) Electronic Health Record (EHR) workflow and documentation requirements included in the RFP, which was very comprehensive. The system seems to be able to provide adequate health information in an electronic format at the facilities. The plan is for the EHR to also connect the state and community providers, initially to begin with the (DRC), followed by ODYS, KALOS Pharmacy, Central Medical Lab, Franklin Medical Center and OSU Hospital records. The program will be customized for each of its users to include links that may be specific to DYS, such as the state immunization records. The EHR is to be piloted at one female adult correctional facility in April 2013. The electronic health record being established will facilitate the sharing of the mental health and medical information. SJCF currently has a Mental Health Database that I observed during the April 2012 visit. Although not all-inclusive, this database includes diagnosis, medication information and medication compliance. Psychology staff that are directly involved with the care and treatment of the Youth at SJCF

	have access to the psychiatry notes. This system can continue to be used until the full development and implementation of eClinical Works.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue to improve the process for sharing of health information between medical and mental health to include psychologists through implementation of eClinical Works EHR. ODYS medical management staff should be intimately involved in the process of customization of the EMR to be relevant to youth medical services. 2. Redact offense-related information from the Disposition Investigation Report contained in the health record.
Sources of Information	• Site visit tour; Review of eight youth health records: ID # Site visit tour; Review of ten youth health records: 217938, 217241, 217635, 217718, 215927, 218016, 218076, and 218098. • Discussion with and documentation provided by Dr. John Bradley, Medical Director, regarding EHR RFP

III.C.5 Access to Health Services. The facilities shall ensure that youth can request to be seen by medical staff confidentially and independent from JCOs and custodial staff.	
Compliance Rating	Substantial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) did not conduct a self-assessment for the level of medical and dental care provided at SJCF during this assessment period.
Steps Taken to Assess Compliance	Health Request call drop boxes were missing on some of the living units, which appeared to be freshly painted. It appeared to be an oversight in replacing the boxes on the units. Health Request boxes were present in the Cafeteria and in the School. Youth interviewed with the exception of one, all knew where the boxes were located and all could verbalize how to gain access to health services. Progress Notes and Nurse Health Requests were reviewed in 8 health records. The original Health Requests are now included in the health record and not in a separate binder as on the previous visit. Health requests included in these health records were responded to adequately and documented by medical staff 100% of the time. Health Requests were reviewed and in each case traced back to a corresponding progress note to determine if the complaint had been addressed. In all cases, the requests had been adequately assessed and treated by registered nursing staff and in some cases by the physician. Most requests were relatively minor such as sore throat, runny nose and skin complaints. There were several related to dental complaints. All were addressed in a timely manner by health care staff.
Recommendations	In order to maintain substantial compliance with this provision, the State must: 1. Ensure Health Request slips and boxes are readily available to youth on all housing units. Youth should not have to rely on custody staff to request forms.
Sources of Information	• Site visit tour; Review of ten youth health records: 217938, 217241, 217365, 217718, 215927, 218016, 218076, and 218098.

SPECIAL EDUCATION

III.E.1 Provision of Special Education. The State shall, at all times, provide all youth confined at the facilities with adequate special education in compliance with the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400-1482, and regulations promulgated thereunder, and this Stipulation.	
Compliance Rating	Partial Compliance
Self Assessment	Prior to the Monitor's visit in October 2012, the State was asked to produce data and explanations for a limited range of issues related to the three education-related provisions that are included in the Amended Stipulation. The first provision pertains to the delivery of special education services in general. In the past, the key compliance issues were related to providing education services to youth who were removed from school during the day or who were held on the unit for disciplinary reasons. *School Safety* Schools cannot facilitate learning if the environment is not safe. Shortly after the facility converted to a long-term placement for medium and close custody youth, the rates of youth violence increased significantly. During the previous monitoring period, school schedules were shifted so that medium custody and close custody boys attended school in different buildings, and the girls attend school separately as well. This appears to have created a safer environment that is much more conducive to learning. With many of the staffing problems now resolved, as discussed below, the safety of the school environment has continued to improve. In the PROGRESS Unit (PU) school, additional YS staff have been deployed to provide extra security during school hours and the classroom environments have been "hardened" (e.g., furniture bolted down, flex keyboards put into use, etc.) resulting in greater safety for both youth and staff. In January 2012, 48 YBIRs were issued in the PU school, compared to only 9 in September 2012. Other elements related to the ability to of students to access and teachers to deliver the special education program are discussed in more detail below. *Staffing Issues* At the conclusion of the previous monitoring period, the school was short two special education teachers, one math teacher and one science teacher. Several more teachers were out on disability leave and the facility did not have sufficient numbers of substitute teachers to cover all the classes. These education staffing problems were compounded by direct care staffing shortages that prevented youth from being

	transported to the school buildings. Throughout most of the previous monitoring period, students did not have dependable access to the daily 330 minutes of instruction required by State law. During the current monitoring period, these staffing issues were largely resolved. Many, but not all, of the vacant teacher positions were filled and nearly all of the teachers on disability returned to work. However, the Science teacher position was vacant for the entire monitoring period. The attendance secretary position was vacant for the last three months (but was filled just prior to the Monitor's visit in October 2012). A Math teacher position became vacant during the last month of the monitoring period. On the positive side, all of the special education teaching positions were filled throughout the entire monitoring period, along with three substitute teacher positions. These improvements in staffing meant that no classes were cancelled due to teacher shortages throughout the entire six-month monitoring period. On the Youth Specialist (YS) side, only two instructional days were modified due to short staffing during the current monitoring period (one in April, one in May, both in the PU school). Improvements are particularly pronounced in the PU school, where classes have been held daily, with very few exceptions, throughout the entire monitoring period. [It is worth noting that some PU students' behavior issues result in frequent periods of seclusion and removal from the school program. Treatment planning and behavior modification efforts for these youth are the subject of a current Dispute Resolution between the Parties.] While vacancies have and will continue to occur, the facility's staffing pattern has returned to appropriate levels and no longer represents a barrier to the youth's ability to access the special education program. *ABC Room* In the past, youth who exhibited non-compliant behavior in the classroom could be suspended from school and returned to their living units where they did not receive education services of any kind. The State ceased suspending students in June 2011, relying more heavily on its in-school suspension room (the Academic Behavior Center (ABC)) and its procedure for Unit Instruction. The ABC room provides youth an opportunity to regain control of their behavior and to return to the classroom setting without going back to their living units. Youth are referred to the ABC room for rule violations pertaining to offensive or threatening conduct, being disruptive, distracting other students or being outside an authorized area. During the previous monitoring period, staff shortages left this resource unavailable to teachers, which frequently resulted in youth being sent back to their units during the school day and the loss of integrity of the

	entire ABC intervention. During the current monitoring period, the boys' and girls' ABC rooms were staffed daily, except for just one day in the boys' school. The number of youth sent to the ABC room during the current monitoring period varied significantly. Nearly three times the number of youth were sent in April (100 youth), May (148), June (94) than in July (32 youth), August (31) and September (21). The source of these variations is likely the significantly lower number of instructional days during the last half of the monitoring period and the stable teacher assignments, which ensured that the ABC rules were enforced more carefully. The length of stay in the ABC room remained relatively constant—most youth stayed between 1.5 to 2 hours. Youth may earn 10 minutes off their ABC time for every 30 minutes they spend focused and engaged in their schoolwork. *Unit Instruction* Previously, the Parties to the *S.H.* lawsuit negotiated an agreement regarding the delivery of education services to youth who are confined to the living units for disciplinary reasons. Within 48 hours of their placement in seclusion, students must receive instruction from a certified teacher four times per day, for at least 30 minutes per visit (i.e., Unit Instruction). The State submitted documentation for Unit Instruction provided during the July-September 2012 grading period and described the process for providing services. Each morning, the Assistant Principal calls each unit for the AOV and Unit Restriction list. A Unit Instruction list is compiled and delivered to all teachers, along with the Unit Instructor schedule. Teachers who serve students on the list prepare course work, along with a copy of the IEP at-a-glance for special education students. The Unit Instructor delivers the work to each student, and also provides 30-minutes of instruction, four times per day. Teachers currently provide the coursework and instruction through the youth's door. This strategy has obvious shortcomings in terms of the quality of instruction. For their part, teachers would prefer to provide face-to-face instruction, but believe that the YS on the unit (rather than the teacher) could likely make a more accurate assessment of whether individual youth could be safely brought to the dayroom. Procedures to make individualized decisions regarding whether students can be safely instructed in the day room need to be established and implemented consistently, in accordance with the Court Order governing this issue in the *S.H.* case.

	The State compiled monthly compliance data regarding the number of youth on seclusion and number of periods that Unit Instruction was required. Compliance rates were reportedly 96% in July, 91% in August, and 96% in September 2012. However, the State cautioned that the reliability of these data might not be solid because three different individuals were managing the data before the new attendance clerk was hired in late September 2012. Additional analysis was undertaken by the Monitor and is discussed below. The school administrators expend significant energy to review and monitor Unit Instruction records to ensure compliance. Each morning, the Assistant Principal reviews records from the prior day to ensure that all students were served. In addition, the DYS Special Education Coordinator reviews these records on a monthly basis. The Coordinator's October 2012 report noted significant improvements in record keeping attributed to the arrival of the full-time Attendance Clerk. The point of internal efforts to monitor performance are not to determine whether procedures were implemented perfectly, but rather to develop systems that are capable of identifying and addressing the problems that will inevitably arise with the complex web of service delivery that characterizes correctional facilities. In this case, the internal monitoring efforts are rigorous, accurately identify problems, and most importantly, lead to corrective action to address the deficits. The quality assurance efforts are a tremendous asset to the State's pursuit of substantial compliance.
Steps Taken to Assess Compliance	*Attendance* Overall school attendance rates are reported every month on the Superintendent's report. Attendance rates during the current monitoring period ranged between 73% and 84%, with a six-month average of 79%. Unit-level attendance rates were calculated based on data submitted by the State. Three-month averages revealed that the boys' general population units had the lowest attendance rates (Jefferson 66%; Carver 77%; Boone 79%), the Progress Units had higher rates (Cedar 82%; Buckeye 82%; Sycamore 85%), and the girls' units had the highest rates (Davey 88%; Allman 94%). While they have still not attained the 85% threshold [agreed upon by the *S.H.* subject matter expert and DYS and commonly used by the Monitor in this case] consistently, the attendance rates are much improved over the attendance rates witnessed in the previous monitoring period. According to school administrators, the attendance data still have "noise" from inconsistent data entry and other data management problems (e.g., students who have left the facility remaining on the population roster and thus being counted as absent). Until these data issues are resolved, the true rates of attendance cannot be known, but it

	appears that recent efforts to improve the accuracy with which data are entered have provided a clearer and more positive picture of students' access to education services. Indirectly related to the attendance issue is a recent School Task Force report that broadly studied youth's and teacher's classroom behaviors to identify strategies to improve school engagement. The facility should be commended for undertaking the project, the rigor of the inquiry (it utilized standardized Functional Behavior Assessment tools) and for developing a comprehensive set of recommendations to improve classroom management and to shift the facility culture to better support the education program. In combination, these strategies should reduce the absences caused by disruptive student behaviors and exacerbated by the staff's and teachers' response to those behaviors. *Unit Instruction* As discussed in the previous Monitors' Report, without a system to cross reference Unit Instruction data with the AMS database's seclusion records, it would be impossible to certify that all youth on seclusion and eligible for Unit Instruction were served. [In the court order, youth on seclusion must be served within 48 hours of their seclusion; in reality, youth are served within the first 24 hours.] To assess the integrity of the Unit Instruction procedures, the Unit Instruction records maintained by the school were cross-referenced with a list of youth who had been on seclusion between July 1 and September 30, 2012 generated by AMS. First, a random sample of 14 youth with seclusion stays well in excess of 48 hours was selected from the AMS list. Instructional days were identified using the School Calendar (there were quite a few non-instructional days during the period of inquiry, e.g., intersession in July, every Friday in August, etc.). Six of the 14 youth (43%) did not serve time on an instructional day (sometimes, the Intervention Hearing officer will schedule intervention seclusion to be served on the weekends so that it does not interfere with the youth's education). Seven of the 8 youth (88%) received seven periods worth of course work on the instructional days during which they were in seclusion. The one exception did not receive Unit Instruction on the last day of his 5-day seclusion. Second, for each of the 38 youth on the Unit Instruction list, the dates of service were cross-referenced with the AMS roster to ensure that youth were served on all of the instructional days during which they were secluded. Service dates were verified for all but 3 of the youth (92% compliance). It is worth noting that about 10% of the Scioto student body received education services via Unit Instruction for a significant proportion of instructional days (between 17% and 30%). While treatment and behavior modification efforts should focus on the

	underlying causes of the youth's behavior in order to minimize the amount of time youth spend in seclusion, until that occurs, Unit Instruction is essential to the effort to maintain the youth's engagement in school. Once cross-referenced with AMS, the Unit Instruction data clearly demonstrated that the facility is in compliance with its obligations around providing education services to youth who are in seclusion. Continued quality assurance efforts are needed to ensure that the preference for youth to receive face-to-face instruction is maximized, and that students receive the full 30 minutes of contact on each of the 4 visits.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Address the preventable causes of absenteeism and address data entry and data management issues to ensure that average attendance rates of 85% or better are achieved for each housing unit. The State is also encouraged to: 2. Continue to maintain Youth Specialist and teacher staffing levels that are sufficient to ensure dependable access to school for youth in all units. Continue to ensure that the ABC rooms are consistently staffed to limit the need for youth to return to the unit during the school day. 3. Continue to provide access to alternative education services for youth in seclusion through the use of Unit Instruction. Ensure that the type, quality and duration of instruction comply with the *S.H.* Parties' agreement. Develop procedures to serve youth in the dayroom, rather than behind their doors, when instruction in the dayroom can be accomplished safely.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.1, prepared at my request • Interviews with n=15 general population youth housed at Scioto on October 19, 2012 • Education staffing roster, January through September 2012 • Unit Instruction data, July through September 2012, and follow-up discussions with Scioto and DYS school administrators via email. • AMS Seclusion Records, July through September 2012 • Attendance records, by unit and by individual youth, July through September 2012 • Scioto School Task Force Report, undated

III.E.7 Individual Education Plans. (a) The State shall develop an IEP as defined in 34 C.F.R. §300.320 for each youth who qualifies for an IEP. Following development of the IEP, the State shall implement the IEP as soon as possible. As part of satisfying this requirement, the State shall conduct required annual reviews of IEPs, adequately document the provision of special education services, and comply with requirements regarding participation by the professional staff, parents and student in the IEP process. The State shall, if necessary, develop, review or revise IEPs for qualified special education students; (b) In developing or modifying the IEP, the State shall ensure that: the IEP reflects the individualized educational needs of the youth and that services are provided accordingly; each IEP includes documentation of the team's consideration of the youth's need for related services and transition planning, and identifies the party responsible for providing such transition services; the student's educational progress is monitored; teachers are trained on how to monitor progress toward IEP goals and objectives; and teachers understand and use functional behavioral assessment and behavior intervention programs in IEP planning and implementation.	
Compliance Rating	Substantial Compliance
Self Assessment	The State provided data on the 35 special education students in custody as of October 1, 2012 (approximately 40% of the total population). Of these youth, two student's IEPs were expired, but they were newly admitted to the facility and staff had already taken steps to collect the necessary information and schedule IEP meetings. The other 33 youth (94%) had current IEPs. Historically, the State has struggled ensure that IEPs include measurable goals and objectives. Training and technical assistance has been on going, with both the facility's Special Education Administrator and Intervention Specialist reviewing draft IEP documents prior to the IEP meetings' being held. Teachers must now complete a Planning Worksheet for each IEP goal that describes how and when the goal will be measured, and by whom. These sheets are attached to every IEP. Only when the IEP goals and objectives are clearly stated can meaningful progress reporting be accomplished. Facilitating students' progress through the curriculum is the entire point of special education, and without assessing progress, the program cannot identify whether it is meeting students' special education needs. The State submitted IEP progress reports for each of the 40 special education students (100%) who were at Scioto at the end of the April-June 2012 grading period, and for the 35 special education youth (100%) who were in custody at the end of the July-September 2012 grading period. That progress reports were sent out for each and every special education student is a significant improvement from the state of affairs when the Monitor became involved with this case. The content of the progress reports is discussed below.

	DYS recently developed and implemented a three-tiered Quality Assurance program for special education. In Tier One, the Special Education Administrator selects a sample of students each month (e.g., six of the 35 current students were selected in September 2012) and conducts a comprehensive file audit. IEPs are evaluated based on a set of criteria that reflect the many requirements of IDEA. Written feedback is provided to the teachers in order to improve teacher skills. In Tier Two, each quarter, the DYS Special Education Director reviews the same files to ensure that all deficits were identified in the local audit and that teachers completed any required corrections. In Tier Three, each of the DYS schools is audited annually by DYS and also tri-annually by the Ohio Department of Education. Results of the audits will be reviewed in future monitoring periods.
Steps Taken to Assess Compliance	*Special Education Population and IEP Development* Across the current special education population, 26 of the 35 students (74%) qualified under the Emotional Disability category, 8 had Specific Learning Disabilities (23%), and one student was Cognitively Disabled (3%). With 6 special education teachers currently on staff, the caseload sizes are well below the state limits (generally, 12 for ED; 24 for SLD). A sample of 15 IEPs were reviewed. The sample consisted of the last 15 IEPs written by Scioto prior to the Monitor's October 2012 site visit which was 43% of the current special education population. In terms of the prescribed level of service, 2 of the 15 students in the IEP sample (13%) were served in the self-contained classrooms on the girls' mental health unit; 10 students (66%) were served in the resource room for between one and four class periods per day (average 2.3 periods) and 3 students (20%) were served entirely in the general education classrooms. In addition, 60% of the IEPs prescribed bi-weekly consultation between the Intervention Specialist and student to discuss behavior and 40% of the IEPs prescribed consultation between the Intervention Specialist and general education teachers. In terms of related services, 13% of the students received services from the Speech-Language Pathologist and 27% received services from the Occupational Therapist. Occasionally, the Description of Specially Designed Instruction section and the services listed in the Least Restrictive Environment section were in conflict, but overall, the level of service prescribed appeared to be individualized and appropriate given the description of the youth's academic and functional performance contained in the IEPs. *IEP Goal Development* The question of whether progress can be accurately measured rests on the quality of articulation of the IEP goals and objectives, which depends, in turn, on clear descriptions of the students' skill deficits. For the most part, the IEPs' Student Profiles contained excellent descriptions of the

	youth's strengths and weaknesses, including a mix of standardized test scores and teachers' observations about the students' capabilities and skill deficits, and descriptions of the youth's behavior and school attendance. The Profiles were much improved compared to the Monitor's previous review. Similarly, the Present Level of Performance section used to set up each IEP goal now includes relevant test scores and descriptions of the students' strengths and weaknesses in the subject matter at hand. While at times the Present Level of Performance sections and Student Profile sections were redundant, the information provided necessary context for the goals and the underlying objectives. Nearly all of the goals reviewed across the 15 IEPs were individualized, measurable and appeared to achievable within a 1-year period, and the objectives identified the skills necessary for the student to acquire in order to meet the goal. Behavior goals are now individualized and anchored in a description of problem behaviors and the situations in which they are likely to occur. Methods to assess progress on behavior goals generally include a combination of citizenship scores, YBIRs, ABC referrals, attendance rates and "working behaviors." All students had transition goals that appeared to be relevant to the student's current grade level and the number of credits they'd earned. Goals were also varied according to students' interests. In summary, IEP goals and objectives were much improved compared to the Monitor's previous review. *Progress Reporting* As noted above, IEP Progress Reports are now created reliably at the conclusion of each grading period. Measuring student progress toward IEP goals is the sole mechanism by which the Parties can discern whether the special education program is meeting students' needs. Finally, after several years of hard work, the Progress Reports generated for Scioto students do just that—provide a tangible, meaningful assessment of the extent to which students have acquired the skills needed to progress through the curriculum. A sample of 10 Progress Reports was selected from among the 40 prepared at the conclusion of the April-June 2012 grading period (25% of all reports). Across these 10 reports, most of them offered detailed, comprehensive descriptions of student progress, particularly for the academic goals. Although a couple of the reports had to work around poorly articulated goals that were difficult to measure, the vast majority had a logical flow between the goal, how it was supposed to be assessed, the information presented, and the conclusion about whether the student was making adequate progress. The only glaring problem was that Progress Reports for 4 of the 10 students (40%) did not have any entry for or discussion about the students' transition goals.

	In order to focus on that particular issue, the transition goals were reviewed for each of the 35 Progress Reports generated at the conclusion of the July-September 2012 grading period. The fruits of the considerable technical assistance delivered to teachers by the Special Education Administrator were easily visible. The vast majority (29 of the 35 reports; 83%) had detailed entries for the students' transition goals, either discussing the things the student's had accomplished or discussing why progress had not yet been witnessed (most often, because the student was not close enough to his or her release date to undertake some of the late-stage transition activities). The remaining 6 cases simply needed more information about why the objective had not yet been undertaken or needed to provide information that was relevant to the specific goal and objective. Together, the Progress Reports from the Summer and Fall quarters demonstrate that the facility is now fully capable of demonstrating their efforts to deliver services that are responsive to students' special education needs and identifying whether those services are helping the student progress through the curriculum.
Recommendations	The State has achieved substantial compliance with this provision.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.7, prepared at my request • DYS Education Quality Assurance materials, April through September 2012 • Review of the n=15 IEPs development most recently at Scioto (43% of the current special education population) • Review of n=10 Progress Reports from the April-June 2012 grading period (25% sample) and the Transition Goals from n=35 Progress Reports from July-September 2012 grading period (100% sample)

III.E.8 Vocational Education. The State shall provide appropriate vocational services that are required transition services for disabled youth under the IDEA.	
Compliance Rating	Substantial Compliance
Self Assessment	Scioto students who are either Juniors or Seniors (by credit) are eligible for vocational programming. Students with low reading or math levels are not excluded from vocational programs. In its self-assessment, the State discussed data on student enrollment in the three currently available vocational classes. On the first day of the 2012 school year (July 23, 2012), of the 63 students enrolled at school: • 14 students (22%) were enrolled in Administrative Office Technology (a course that teaches students how to use various computer applications to prepare them for clerical, data entry, graphics, or other office-based jobs); • 4 students (6%) were enrolled in Career-Based Intervention (i.e., work-based learning, student earns credit); and • 27 students (43%) were enrolled in Transition Skills (students must take this course prior to release; includes job skills, resume building, interview skills). Overall, 43 students were enrolled in vocational programming (two students were taking two classes), which is 68% of the student population. By the end of the grading period (October 5, 2012), enrollment had shrunk a bit to 58% of the student population. This is a significant improvement over the previous monitoring period where less than half the students were involved in vocational programming. School administrators indicated that they have not expanded the capacity of any of the programs, but have simply emphasized these programs, encouraging teachers to identify students who need vocational programming. Each of the three courses have sufficient capacity to serve significantly more students if they were eligible and needed vocational programming. The Ohio DYS vocational programs were audited twice during the current monitoring period. First, the ODE Office for Exceptional Children audited DYS's special education program. IDEA requires the IEPs for students age 14 and older to include a Transition Plan to ensure that the school delivers services in preparation for life *after* graduation (and, in this case, after they return to the community). The audit found Scioto to be in compliance with the standard related to Transition Planning (SPP Indicator 20 for Secondary Transition Plans). Specifically, ODE found that Scioto's plans "prescribed reasonable services to meet post-secondary goals." In other words, Scioto youth have access to courses that address their pursuits after high school. In addition, ODE's Office of Career-Technical Education conducted a

	comprehensive review of all career-technical education programs offered at Scioto. Through teacher surveys, document review and on-site program observations, the audit noted significant improvement in the participation rates in Scioto's vocational programs (mirroring the Monitor's findings discussed below). In addition, the audit noted that vocational textbooks were current and that supplies and facilities were adequate. The report's Opportunities for Improvement included a variety of suggestions to improve the administration of the programs (e.g., involving Central Office in vocational teacher hiring; improving communication) or to enrich the curriculum delivery (e.g., developing a method for internet access with appropriate firewalls; emphasizing employability skills in all courses). The audit also recommended that the DYS formalize student's course completion via industry-based credentialing tests and formal graduation ceremonies. Notably, the ODE did not require or advise any modifications to the course offerings, apparently finding they were adequate to meet the needs of students.
Steps Taken to Assess Compliance	While the facility has not enhanced the array of vocational options since the Monitor's previous review, it has significantly increased the proportion of youth who are engaged in vocational programming. Some of Scioto's students simply are not eligible (because they are too young or have not earned enough credits). All eligible general population students have the opportunity to participate in vocational programs; however, some students choose to focus on college prep materials and may not choose to take vocational courses as a result. Youth on the PU may not enroll in vocational courses during their stay on the PU. The CBI and AOT courses require the freedom to travel throughout the campus (which PU youth do not have) and also require the student to have completed all 16 credits of the core courses, which most PU students have not yet achieved. All youth take the Transition Course at some point 3 to 6 months before their scheduled release date. While the Monitor would prefer to see additional options for hands-on learning and opportunities for youth to earn vocational certificates that could assist in their future job searches, Scioto's program options are adequate. In particular, these services can fully address the transition needs and services prescribed in Scioto's IEPs which include completing career interest inventories, conducting job opportunity searches, developing employability skills, and compiling transition portfolios. The improvements noted in the facility's IEP goal articulation and progress reporting makes it easier for the Monitor to certify the compatibility between student needs and the transition program resources available to special education students. Finally, particularly now that the facility has a well-developed program for graduates, the opportunities for students to develop job and

	employability skills are far greater than they were at the time Stipulation was signed.
Recommendations	The State has reached substantial compliance with this provision.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.8, prepared at my request • Student rosters for each of the three vocational courses, April-June and July-September 2012 grading periods. • ODE Office of Exceptional Children audit report, November, 2012 • ODE Office of Career-Technical Education audit report, November 2012