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

Civil Action No: 2:08-cv-475

Monitor's Fourth Report

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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, signed June 28, 2011, 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 fourth report on the State's progress toward the reforms required by the Amended Stipulation. The monitoring period is October 1, 2012 through March 31, 2013. Progress reports are issued approximately every six months. This report includes only Protection from Harm, Medical Services and Special Education. DYS was unavailable to present the required self-assessment of Mental Health Services until just before the report's due date, leaving Dr. Glindmeyer with insufficient time to integrate the State's assessment with her own. The draft Mental Health report was submitted to the Parties for review and comment on June 17, 2013. The absence of information regarding Mental Health Services in this report should not be construed to mean that the State is in substantial compliance with those provisions.

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 and subject matter experts 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 <u>all</u> 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	4th Report
Protection From Harm					
III.A. 1	General Protection From Harm	NC	PC	PC	PC
III.A.3	Seclusion	NC	PC	PC	PC
III.A.5	Investigation of Serious Incidents	SC	PC	PC	PC
III.D.1	Grievances	PC	PC	PC	PC
III.D.2	Grievances Explained to Youth	PC	SC	SC	SC
III.F.1	Structured Programming	NC	NC	PC	PC
III.F.2	Orientation	PC	PC	PC	SC
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 Unidentified 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	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 Line 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					
No.	Provision	1st Report	2nd Report	3rd Report	4th Report
III.C.1	General Medical Care	SC	PC	PC	PC
III.C.2	Health Records	SC	PC	PC	PC
III.C.5	Access to Health Services	SC	SC	SC	SC
Special Education Services					
III.E.1	Provision of Special Education	PC	PC	PC	SC
III.E.7	Individual Education Plans	PC	PC	SC	SC
III.E.8	Vocational Education	NC	NC	SC	SC

Overall compliance rates could not be calculated because the Mental Health section is not included with this report. Individual sections of the Stipulation are discussed below.

<u>Protection from Harm (includes Grievances and Programming)</u>

The facility is in substantial compliance with 2 of the 7 provisions (29%) related to protecting youth from harm and is in partial compliance with the remaining 5 provisions (71%). The following actions should be prioritized:

- Assess the effectiveness of the various strategies that have been recently implemented to address the problem of youth-on-staff violence. Make modifications as necessary to effect substantial reductions in the rate of youth-on-staff assaults.
- Reinforce the prohibition against provoking, taunting, belittling and otherwise disrespecting youth. Investigate complaints vigorously and enforce the conduct standards when they are violated.
- Improve staff accountability measures to ensure that all staff are held responsible not just for maintaining the code of conduct, but for reporting concerns about staff who fail to do so.
- Develop a robust Quality Assurance/Quality Improvement process to determine whether the IRAV and sanctions grid revisions are properly implemented and whether they have significantly reduced the reliance on isolation to control and respond to youth behavior. The QA/QI process should include standards that clearly articulate a preference for non-seclusion based sanctions when appropriate, a methodology for auditing facility practices, analysis and interpretation of data, and a Quality Improvement Plan for any area in which performance deficits are revealed.
- Reduce the number of individuals authorized to conduct local 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.
    - *The lack of progress in the area of Local Investigations suggests that additional oversight may be necessary. The Monitor encourages DYS to create a Quality Improvement Plan that determines the underlying causes of the delay and poor*

quality products. Once known, specific strategies should be developed to target each underlying factor so that the quality of the product is significantly improved. The effectiveness of these strategies should be assessed frequently (e.g., monthly or bi-monthly). The Monitor will request copies of completed local investigations on a monthly basis in order to provide more frequent progress reports to the Parties and to the Court.

- Promptly notify youth of the outcome of any grievance referred for investigation. [If DYS completes this straightforward task very soon, the provision may be rated in Substantial Compliance for the April-October 2013 monitoring period.]
- Create and implement a Quality Improvement Plan to improve compliance with Quality Assurance standards related to all three components of Structured Programming (i.e., MAV, Victim Awareness and Phoenix groups; recreation and community service; religious and volunteer-led programs).

Mental Health Services

DYS was unavailable to present the required self-assessment of Mental Health Services until just before the due date, leaving Dr. Glindmeyer with insufficient time to integrate the State's assessment with her own. The draft Mental Health report was submitted to the Parties for review and comment on June 17, 2013. The absence of information regarding Mental Health Services in this report should not be construed to mean that the State is in substantial compliance with those provisions.

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.
- Continue to limit time of youth in seclusion and adequately document health status in during segregation.
- Continue to improve Quality Assurance (QA) activities by continuing an external review through accreditation by the American Correctional Association. ODYS should also consider expansion of the QA process to include some additional quality outcome indicators.
- 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.
- 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.

Special Education

The facility is in substantial compliance with all 3 of the education-related provisions (100%)!

During the current monitoring period, the Parties negotiated a Consent Order regarding the operation of the PROGRESS Unit (PU). Signed by Judge Marbley on January 18, 2013, the Order requires specific modifications to the PU that are monitored separately from the Amended Stipulation. The most recent Status Report for the PU is attached to this report. Once the State comes into substantial compliance with all of the provisions and maintains that level of performance for six months, monitoring of the PU shifts back to the Amended Stipulation and will be reported here in the sections for the relevant provisions. The operation of the PU is therefore not discussed in this report.

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	Trends in youth violence, restraints, and allegations of over-familiarization are discussed here, while detailed discussions about the use of seclusion and investigating staff misconduct can be found in III.A.3 and III.A.5 respectively. Via its work on the *S.H.* case, several new Quality Assurance (QA) programs have been established to provide the internal capacity to identify and respond to problems in the core areas of youth violence, investigations, and seclusion. These join pre-existing efforts to track facility performance (youth violence) and offer technical assistance (restraints). However, the QA programs in each area are in different phases of development. Some have articulated standards, some have an articulated audit methodology and performance measures, some have pilot tested the methodology. To date, a "QA Report" on the success with which the facility has met the standards and performance measures in each area has not been produced. Further, structured Quality Improvement Plans have not yet been developed to remediate identified deficits. DYS' progress in sculpting a formal QA process is an important accomplishment, although significant work still remains. *Quality Assurance Efforts Related to Youth Violence* DYS has leveraged its participation in the Performance Based Standards (PbS) project to provide a framework for its QA process in this area. Data on the rate of youth-on-youth and youth-on-staff violence is collected monthly and progress is measured using the 6-month PbS cycle (every April and October). Each facility is expected to reduce its rates of youth violence by at least 10% each reporting period. While the facility has participated in PbS for several years, the full QA framework for identifying the underlying causes of increases or decreases in youth violence was established only recently. Each month, the Bureau Director of Facility Programs meets with each Facility Superintendent to discuss the various influences on youth violence and to create strategies for addressing them. During the first two months that the QA program was operational (January and February, 2013), conversations with the Scioto Superintendent focused on the two youth who were responsible for nearly half of the youth-on-staff assaults. These two youth had been referred to the PROGRESS Unit. In addition, the agency-wide "Back to

	Basics" strategy was identified as a tool to fortify the supervision and teamwork skills of direct care staff. *Quality Assurance Efforts Related to Restraints* As discussed in the previous Monitor's Report, the DYS has a system for both internal and external QA. Scioto's 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 Facility Resource Administrator (FRA) from DYS Central Office reviews the FIA's assessment and decision-making for a sample of incidents occurring in that month. Since the previous monitoring period, the FRA's reviews suggest that the detection of "teachable moments" has improved. The FIA now keeps a log of these opportunities, which both documents the substance of the issue and verifies that the staff involved received feedback. Both of these mechanisms are essential for the ongoing training of new staff and refining the skill sets of veteran staff. The weak link in this system, however, is the poor quality of the local investigations, which are discussed in depth in III.A.5, below. When a more serious concern about the use of restraints is detected by the FIA, the incident is referred for investigation. That referral is a sound practice, however, the poor technique of many of the facility-based investigators seriously undermines the integrity of this process and offers youth little protection from undue restraints.
Steps Taken to Assess Compliance	*Youth Violence* The table below presents the rate of youth-on-youth and youth-on-staff violence for the past 24 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. The average rate for the current period was .09, even with the spike in violence in November 2012. Overall, rates of youth-on-youth violence have been low for a little over one year. Unfortunately, the rate of youth-on-staff violence has been more resistant to change. The average rate of youth-on-staff violence increased over the past three six-month monitoring periods, and recently leveled off (i.e., .15, .16, .20, and most recently, .17). Youth-on-staff assaults occurred almost two times as often as youth-on-youth assaults. Several of the youth-on-staff assaults were very serious, with staff admitted to the hospital. Conversations with facility administrators revealed some solid problem-

solving efforts around this issue. Profiles of staff victims tend to fall into three categories: 1) vulnerable staff who are new, frightened, and inexperienced; 2) staff who fail to identify the youth's immediate behavioral cues that indicate a heightened risk of violence; and 3) accountability-focused staff who are targeted by youth in an effort to get the staff removed from the unit. Efforts to better protect these victims are underway. For example, encouraging the unit staff to function as team so that all staff are better supported, so that operational practices are consistently implemented, and so the team is less susceptible to youth's efforts to split staff and exploit their vulnerabilities.

Other, less serious forms of youth-on-staff violence have been addressed via environmental strategies such as container-less meals (to prevent youth from being able to collect and throw liquids at staff) and spit masks (to prevent youth from being able to spit on staff).

These two approaches—efforts to better protect victims and environmental strategies that make the offenses more difficult to accomplish—are essential supplements to efforts that address the youth's behavior, decision-making, empathy or sanctions. While the facility still has much to do to create a safer environment for staff (and to shield youth from the consequences they will and should face when they engage in that type of violence), its recent efforts to focus on the underlying causes of youth-on-staff violence are very promising.

That said, the Monitor and DOJ Attorney continued to hear complaints from youth about their frustrations 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. The solution to this problem has many facets, such as reiterating and enforcing requirements around appropriate behavior and demeanor among staff, teaching staff skills for tolerating their frustrations with youth, and holding them accountable for failing to meet these standards. On the other hand, helping youth to develop skills for tolerating frustration, making requests appropriately, controlling impulses, etc. should also contribute to a reduction in the rate of youth-on-staff violence.

Youth Violence, April 2011 through March 2013

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
Oct 12	4	76	.05	15	76	.20
Nov 12	17	82	.21	15	82	.18
Dec 12	9	72	.12	11	72	.15
Jan 13	3	62	.05	11	62	.18
Feb 13	4	59	.07	12	59	.21
Mar 13	2	60	.03	7	60	.12

Use of Restraints

The previous Monitor's Report discussed the decline in the use of restraints witnessed during that monitoring period and how it could be attributed primarily to decreases in the use of restraints among the female population at Scioto. During the current monitoring period, the average rate of physical restraint use declined across the board, despite a spike in the use of restraints in November 2012 that mirrored the spike in youth-on-youth violence. Over the past three monitoring periods, the average rate of physical restraint use for the total population was .72, .62 and, most recently, .47. This represents a 24% decrease from the previous monitoring period. Note that the rate of restraints decreased more sharply than the more modest decreases in youth violence would suggest.

Separated by gender, the average rate of physical restraint use for males and females has equalized. Previously, the males' 6-month average rates were .56 (Oct 11-Mar 12), .58 (April 12-Sept 12). The average rate for the current monitoring period (Oct 12-Mar 13) was .47, which represents a

19% reduction from the previous period. The females' 6-month average rates were 1.31 (Oct 11-Mar 12), .73 (April 12-Sept 12), and .47 for the current monitoring period (Oct 12-Mar 13), which represents a 36% reduction from the previous period.

These statistics suggest positive changes are occurring at the facility. For one, the population continues to decrease, which may provide staff with additional time and patience to utilize their verbal strategies to de-escalate youth who lose control. In addition, the facility's population of girls with serious mental health issues continues to decline as they are placed in alternative settings. Historically, this group of girls was restrained more often than youth in the general population.

Physical Restraints, October 2011 through March 2013

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
Oct 12	27	76	.36	23	64	.36	4	12	.33
Nov 12	63	82	.77	56	68	.82	7	14	.50
Dec 12	37	72	.51	28	58	.48	9	15	.60
Jan 13	36	62	.58	28	47	.60	8	16	.50
Feb 13	22	59	.37	18	42	.43	4	16	.25
Mar 13	16	60	.27	6	43	.14	10	18	.56

As noted in the Introduction to this report, the functioning and operational practices on the PROGRESS Unit are discussed in a separate document, which is attached to this report. The use of mechanical restraints with Phase I youth continues to be a concern for both the

	Monitors and the Plaintiffs, and discussions about how to mitigate any harmful effects of their use are on-going. *Staffing* Adequately staffing the facility to ensure youth and staff safety and youth access to programming has been an ongoing challenge for Scioto. However, recently, the various strategies enacted to ensure adequate numbers of direct care staff report to work have begun to reap dividends. As noted in previous Monitor's Reports, the facility began to hold Involuntary Disability Separation (IDS) hearings in January 2012. These hearings vacated positions historically filled by staff who had exhausted their leave benefits, positions which could then be filled by someone who was willing and able to report to work. The commitment to ensure that direct care staff positions are functionally occupied has continued. During the current monitoring period, DYS held 18 IDS hearings (and won 16 of those). In addition, DYS closed one girls' (Hunter) and one boys' (Carver) general population unit. While there were several factors underlying this decision, one of them was to alleviate the chronic staff shortages that had plagued the facility for years. Hunter Unit was closed at the end of June 2012, and more recently, Carver Unit was closed in December 2012. Hunter staff bid on and were placed on other posts; Carver staff were placed in the relief pool to assist with staff coverage in other areas of the facility. Both Hunter and Carver staff positions are still considered in the facility's staffing allocation, which makes the facility's data on staff vacancies and overtime difficult to interpret. Furthermore, the facility's population is very low, but the number of mandated positions allocated to each unit via the Pick-A-Post collective bargaining agreement has not yet been adjusted. As a result, the facility is required to call staff in and pay them overtime to cover a shortage, even though the staff-to-youth ratio would fall within the generally accepted practice. For all of these reasons, on paper, the Scioto staffing situation appears to be worse than it is. Except for one situation in November where youth were confined to their rooms for 43 minutes during the normal wake up and hygiene routine, staff shortages have not resulted in a lack of access to youth programming or services. As discussed in the previous section, youth-on-youth violence remains low. Perhaps most telling are the statistics related to the number of staff off work—during the previous monitoring period, a whopping 47 staff on the roster were not reporting to work. More recently, that number hovers around 6 staff. The facility continues to address the factors that result in the abuse of the time/attendance policies. Furthermore, given that most of the turnover

occurs among interim staff (who work full time, but who do not receive benefits), stabilizing this segment of the workforce continues to be a priority. New initiatives to recognize high-performing staff and to fortify the mentoring relationships created via On-The-Job training are also underway.

Investigations Related to Use of Force, Seclusion or Abusive Practices
Over the past six months, 50 allegations of excessive or inappropriate uses of force, verbal or other misconduct were investigated, 13 by the Chief Inspector's Office (CIO) and 37 by a facility-based investigator. This is a significant increase over the previous six-month period, when 28 investigations were completed. [During the previous monitoring period, a large number of investigations were "pending" which may account for the difference in the number of investigations completed and available for review.]

Across the 50 investigations, 18 were substantiated (19% of the local investigations and 85% of the CIO investigations, 36% combined). Among them:

- 9 (50%) involved an unsanctioned restraint technique (e.g., elbow in the youth's face; hooking an arm around the youth's neck; unsafe take down; laying on a youth who was prone; dragging a youth by his shirt);
- 3 (17%) involved an inappropriate comment or behavior (e.g., a comment about a youth's mother; using gang-related hand signals; backing into a youth's room in a suggestive manner);
- 2 (11%) involved physical abuse or an abusive practice (e.g., exchanging punches with a youth; cutting off a youth's water and vent); and
- 4 (22%) involved improper procedures (e.g., failing to use the handheld camera and notifying Operations about a youth's refusal to remove restraints; failure to report a fight or use of force; leaving post without relief; bringing a personal cell phone into the facility; inappropriate contact with youth via FaceBook).

As noted in prior reports, the poor quality of the local investigations creates concern about the extent to which staff who use force improperly or otherwise mistreat youth 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.

Allegations of Inappropriate Relationships
Each of the previous Monitor's reports discussed the problem of allegations of sexualized comments by staff and inappropriate relationships between Scioto staff and youth. Historically, 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 continued to report inappropriate comments and behaviors by staff to the Monitors, DOJ attorneys and facility staff. For the first time since the Monitor became involved in the case, none of the girls interviewed reported an inappropriate relationship or sexually inappropriate comments or conduct to either the Monitors or the DOJ Attorney (all but two of the girls in custody were interviewed by one or the other). There were a few grievances about sexualized comments by female staff to male residents (none of which were found to have merit by the facility's Grievance Coordinator) and one grievance about sexualized behavior by female staff toward a male resident (which was sustained; involved a female staff backing into a youth's room in a suggestive manner). Otherwise, neither the Monitor nor the facility has been made aware of continued problems in this area. However, a recent report by the Bureau of Justice Statistics (Beck, A., D. Cantor, J. Hartge and T. Smith (2013) *Sexual Victimization in Juvenile Facilities Reported by Youth, 2012.)* ranked Ohio, and Scioto in particular, among the highest in the nation for sexual assault committed against incarcerated youth, suggesting that serious problems remain. At the time this report was issued, the Governor Kasich had convened an interagency Task Force to develop immediate, short and long-term remedies to address the problem. Progress implementing those remedies will be reviewed in subsequent Monitor's Reports. <u>*Verbal Mistreatment*</u> Although no new allegations of inappropriate relationships or sexualized language or behaviors were reported to the facility, the Monitor or the DOJ Attorney, youth continue to report that staff provoke, antagonize, belittle or otherwise interact in unprofessional, counterproductive and hurtful ways with youth. 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. Many of the youth interviewed by the DOJ attorney 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.

However, from the discussions with youth, it appears that the problem is not the lack of a forum to voice their concerns (all of the youth gave the Grievance process high marks), but rather in their belief that the facility will not act on their complaints. The delays in assigning and completing local investigations of their complaints and the poor quality of the investigations (which rarely lead to a sustained finding) likely contribute to this perception. Improving the quality of the local investigation process may create additional opportunities to hold staff accountable in a way that may be persuasive to staff who persist in acting with impunity, and may help youth to gain confidence in the system.

Tools to Ensure Staff Accountability

The DOJ launched its investigation at a time when over 10% of the facility's staff were under indictment for physical or sexual abuse of Scioto youth. Since then, the DYS has enacted a number of measures intended to prevent the reoccurrence of such a tragedy. Some of these measures have been well implemented and definitely improve the State's ability to protect youth from harm at the hands of staff. Among them:

- Additional stationary and hand-held video cameras;
- A robust grievance process;
- Revised policies and procedures; and
- Investigations by the Chief Inspector's Office.

Other measures are less well-developed, but if fully implemented, could add additional protection:

- Compliance with PREA standards;
    - *In particular, the facility should develop guidelines to prohibit staff from being alone with youth in places that do not have either camera surveillance or natural surveillance opportunities. The DYS has already made substantive efforts to move toward compliance with PREA standards (e.g., policy review and revision; staff training; youth education). Scioto is scheduled for a "Vulnerability Assessment" before the end of 2013, which should indicate the extent to which PREA standards are being met.*
- "Healthy Boundaries, Healthy Relationships" group;
    - *During the first half of the monitoring period, the facility delivered the second cycle of its 6-week "Healthy Boundaries and Relationships" group, co-facilitated by a contracted provider and the girls' social worker. Progress notes for the August-October 2012 group revealed 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.). It appears*

	this group is held only twice per year (once in the previous monitoring period, once in the current monitoring period). Positive reviews from the girls who have attended the program, and the unique forum for identifying potentially inappropriate relationships among youth and staff, suggest that the group should be delivered continuously. • Forum during Interdisciplinary Team (IDT) meetings; o *The topics of over-familiarization and boundary issues between staff and youth were incorporated into the staff portion of the weekly Interdisciplinary Team (IDT) meetings. The facility provided IDT minutes from six meetings that occurred during the current monitoring period to demonstrate the extent to which this strategy had been implemented. The topic was broadly defined to include youth who may be touching each other inappropriately and youth who seem to be developing crushes on staff and behaving inappropriately. For the most part, the conversations revolved around youth having inappropriate relationships with each other and little evidence was available to establish that staff-youth boundaries were discussed with staff, even when there were clear indicators of such dynamics (e.g., two female youth were arguing because they both had a crush on the same YS). While the forum for these discussions has clearly been established (it is a standing agenda item on the IDT minutes), the discussions appear to lack substance or pointed conversations about staff's involvement in these situations. Two recent investigations of inappropriate relationships between youth and staff suggested that several staff had concerns about the YSs' poor boundaries and inappropriate relationships with the alleged victims, yet none of them addressed the matter in the Unit's IDT meetings or otherwise reported their concerns.* While these measures are surely a step in the right direction, they nonetheless fall short of substantial compliance with the portion of this provision related to protecting youth from harm at the hands of staff. During a recent conference call between the State, DOJ and the Monitor, the DYS agreed to pursue the following strategies in order to more fully develop its process for staff accountability: • Reconfiguring the local investigations process by, for starters, seeking to create a position for a dedicated facility-based investigator; o *As noted throughout this report, the poor quality of the local investigations is the weak link in the system. Without a solid mechanism to determine the veracity of youth's allegations and to hold staff accountable for*

	violating policy, the culture change that the DYS seeks to catalyze will be impossible to achieve. • Fortifying the policy language and enforcement of mandates for staff to uphold the standards of conduct and to report instances when they observe other staff not upholding those standards. o *Once established in policy, compliance with these standards needs to be addressed through the investigations into these peripheral issues that emerge while investigating an allegation of staff mistreatment.* Until the DYS has established a dependable mechanism to investigate and hold staff accountable for their failure to protect youth from harm, and for the instances in which they, themselves, are the source of harm, the DYS will not be able to achieve substantial compliance with this provision.
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. Implement and assess the effectiveness of interventions that target the underlying causes and patterns of youth-on-staff violence. Make modifications as necessary to effect substantial reductions in the rate of youth-on-staff assaults. 3. Address the poor quality of local investigations to improve the ability to protect youth from harm related to inappropriate uses of force and verbal abuse (e.g., provoking, taunting, belittling and otherwise disrespecting youth). 4. Improve staff accountability measures to ensure that all staff are held responsible not just for maintaining the code of conduct, but for reporting their concerns about staff who fail to do so.
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, October 2012 through March 2013 • Monitor's Monthly Data, Scioto Male and Female Population, 2012 and 2013, to date • CIO and local investigation log, October 2012 through March 2013 • CIO and local investigations completed between October 2012 and March 2013 • Description and Group Notes from "Healthy Relationships and Boundaries" groups, August through October 2012 • IDT Minutes from October 2012 through March 2013 that document conversations surrounding boundary issues between

	youth and staff • Interviews with youth housed at Scioto between March 24-26, 2013, in consultation with other Monitors and the DOJ attorney who interviewed approximately 20 youth housed at the facility • Review of 13 CIO investigations completed since October 2012 (100% of total) • Review of 37 investigations conducted by Scioto staff since October 2012 (100% of total)

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	Although the facility provided a large volume of data on the use of seclusion at the Monitor's request, its interpretation was challenging for a number of reasons. First, the facility had yet another change in Superintendent and thus the sense of "starting over" with regard to the role that seclusion would play in the facility's disciplinary process was predominant. Second, the IRAV policy and Sanctions grid underwent a major transformation at the end of the current monitoring period. Although its formal implementation did not occur until April 2013, just after the monitoring period ended, conversations with DYS Administrators suggested that in some places, the reforms began to seep into the facility's practices even in advance of the policy's formal implementation. Both of these changes are very positive and the Monitor anticipates significant changes to the use of seclusion in the upcoming monitoring period (April through September 2013). In terms of Quality Assurance, the facility has multiple tools at its disposal. First, each month, the Facility Superintendent is required to report seclusion hours in the *Superintendent's Monthly Report* and must explain any increases or decreases in the various categories of seclusion. These explanations generally connect the consumption of seclusion hours to the number of AOV and the number of youth involved, but do not look at whether the seclusion procedures, themselves, were properly implemented. Second, the Central Office's Facility Resource Administrator (FRA) reviews the use of seclusion on a monthly basis and discusses any procedural problems (e.g., exceeding the maximum length of stay; failing to make safety and welfare checks at the required intervals). For the first three months of the monitoring period, the FRA noted a variety of deficiencies in the documentation (e.g., lack of supervisory approval for continuation or release, lack of information regarding the reason for seclusion, exact 15-minute increments on the monitoring logs). In addition, the FRA noted that large proportions of youth were being held in pre-hearing seclusion for the maximum allowable time, even when an Intervention Hearing was not utilized. The FRA encouraged the facility to hold the hearings more quickly so that the length of stay in pre-hearing confinement could be reduced. By February 2013, these deficiencies had been corrected, which suggests that the FRA review and communication with the Direct Deputy, and others, is an effective avenue for program improvements.

	Finally, via the *S.H.* stipulation, the facility designed a QA process to monitor the implementation of the IRAV and sanctions grid revisions. Unfortunately, the rollout of the policies did not coincide with the monitoring period for this report, and thus complete results are not available. However, the first month of the revised IRAV's implementation (April 2013) produced some encouraging reductions. To maximize its effectiveness, the QA process should be anchored to a set of standards that clearly articulate DYS' objectives regarding reducing the use of seclusion.
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. During the 2nd monitoring period (October 2011-March 2012), regular seclusion was used at a rate of .43 (rate = # seclusion episodes/ADP). This rate increased 23% during the 3rd monitoring period to .53. The 3rd Monitor's Report also noted an increase in the length of stay in regular seclusion. Between 15% and 20% of youth who were placed in regular seclusion remained there for longer than what would normally be considered a "cool-off." [The average length of stay was 7 hours.] During the current monitoring period, these problems were resolved. The rate of regular seclusion returned to its previous level, .43. More significantly, 95% of regular seclusions lasted 4 hours or less, with the average length of stay decreasing considerably, to 1.6 hours. These length of stay statistics reflect a practice that is far more in line with generally accepted practices regarding a "cool-off." Quality assurance efforts, particularly those by the FRA, should continue to reinforce and encourage this trend.

Regular Seclusion, October 2012 through March 2013				
Month	#	Rate (#/ADP)	% 4hrs or less	ALOS (hrs)
October 2012	42	.55	100%	1.4
November 2012	25	.30	88%	1.6
December 2012	28	.39	93%	1.7
January 2013	21	.34	100%	1.4
February 2013	28	.48	89%	1.9
March 2013	31	.51	94%	1.7
Source: Data prepared by DYS to respond to the Monitor's request for information on				

the use of seclusion.

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 must receive recreation and Unit Instruction (i.e., education), although the instruction is delivered through the youth's door. 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 to 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, nearly all PHS episodes exceeded 24 hours and the average length of stay was 53 hours.

As noted above, DYS revised the IRAV policy during the current monitoring period, incorporating most of the suggestions discussed in the previous Monitor's Report. The policy was scheduled to be rolled out in April 2013; however, with changes on the horizon, the length of stay in PHS began to decrease even before the policy was issued. In the first half of the monitoring period, no major changes were evident. An average of 90% of pre-hearing seclusions lasted more than 24 hours and the ALOS was 54 hours. In the second half, however, the proportion lasting more than 24 hours decreased to 66% and the average length of stay decreased to 37 hours (a 30% decrease). Across the IRAV levels, far more youth were released prior to the maximum allowable time for each level and ALOS also decreased within each level. Once the new IRAV policy is implemented, it is likely that these decreases will become even more pronounced.

Notably, the new IRAV policy brings additional and more frequent opportunities for youth to be released from PHS once they demonstrate a willingness and ability to return to the general population safely. Individualizing the length of stay in PHS this way is far more compatible with the generally accepted practice than the historical reliance on pre-determined lengths of stay.

Pre-Hearing Seclusion, October 2012 through March 2013				
Month	#	Rate (#/ADP)	% 24+ hours	ALOS (hrs)
October 2012	23	.30	96%	61
November 2012	63	.77	86%	52

December 2012	28	.39	89%	50
January 2013	24	.39	58%	36
February 2013	20	.34	65%	38
March 2013	12	.20	75%	36
Source: Data prepared by DYS to respond to the Monitor's request for information on the use of seclusion.				

Intervention Seclusion

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 must receive recreation and Unit Instruction (i.e., education) outside of their rooms. By policy, youth can receive Intervention Seclusion for a primary rule violation, some of which are non-violent (e.g., exposure). The Hearing Officer can impose a maximum of 5 days of Intervention Seclusion, but policy also allows for the use of alternative sanctions to respond to primary rule violations.

During the current monitoring period, the DYS revised policies regarding the Intervention Hearings (requiring them to be held more quickly) and Sanctioning process (instituting a new sanctions grid that limits discretion and significantly reduces the amount of seclusion that can be imposed). These policies are scheduled to be rolled out in May 2013 and are expected to reduce the State's reliance on seclusion as a sanction.

While these changes are very positive and certainly headed in the right direction, it is worth noting that the use of isolation as a disciplinary sanction is increasingly being prohibited by juvenile justice systems throughout the country. Research on the deleterious effects of isolation on youth's mental health suggests that skill-based, restorative and treatment-focused responses and sanctions available through the behavior management/incentive system are less harmful and more effective than isolation in changing youth's behavior. The Monitor strongly encourages DYS to reconsider its use of disciplinary isolation.

The new IH policy and sanctions grid will ensure that an increasing proportion of rule violations are 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.

As shown in the table below, the use of intervention seclusion varied

across the monitoring period, with rates ranging from a low of .18 to a high of .47, with no obvious patterns. [Using a rate, rather than the number of youth, neutralizes the impact of changes in the size of the population.] Given that a small number of youth are involved in a disproportionate number of seclusion events, a rate of use across the population simultaneously overestimates (by making the practice seem more widespread than it is) and underestimates (by ignoring the effect of repeated seclusion experiences on a single youth) the impact of the practice. For these reasons, it is not a particularly useful statistic.

Monthly AOV spreadsheets track the disposition of each AOV. These data indicated that, on average, seclusion was used to sanction 72% of the youth who committed AOVs (monthly percentages ranged from 60% to 88% across the monitoring period). Once the new grid is imposed, DYS should monitor its implementation and encourage the use of seclusion only as a last resort. Quality Assurance efforts should also examine individual cases to determine whether the full range of non-seclusion sanctions have been exhausted prior to imposing seclusion.

The total number of Intervention Seclusion hours varied widely across the monitoring period, driven by the number of youth who received it as a sanction (e.g., the spike in youth violence that occurred in November 2012 doubled the number of youth who were placed in seclusion, and led to longer lengths of stay, which drastically increased the total number of hours). Similarly, the ALOS varied throughout the monitoring period, with no obvious patterns. Except for those who received IS in November 2012, the average youth spent approximately two days in Intervention Seclusion (which followed a period of Pre-Hearing Seclusion).

Intervention Seclusion Hours, October 2012 through March 2013

Month	# Y who received IS	Rate (# Y/ADP)	Total IS hours	ALOS
Oct 2012	14	.18	595	42.5
Nov 2012	39	.47	3,312	84.9
Dec 2012	17	.23	657	38.6
Jan 2013	20	.32	1,001	50.5
Feb 2013	20	.34	881	44.0
March 2013	15	.24	733	48.9

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

Although aggregate data is useful for identifying trends and overall

	increases and decreases in the use of seclusion, it can mask the impact of the facility's disciplinary strategy on individual youth. A review of AMS Seclusion records for the Special Education provisions of the Stipulation casts this problem in sharp relief. One youth, CC, spent 16 consecutive days in seclusion, with only one 24-hour period in the general population. Another youth, TB, spent 8 consecutive days in seclusion. While these youth committed serious acts of violence, their long stays in seclusion likely exacerbated their anger and frustration and did nothing to help them develop the anger management skills, impulse control, empathy, etc. they so desperately needed. In this way, the use of seclusion may very well exacerbate the exact problems that the facility is trying to solve. The Monitor strongly encourages the State to seek other ways to manage and respond to youth's behavior. *Quality Assurance* Pilot testing of the Quality Assurance process developed via the *S.H.* case was limited due to the mismatch between the Order's termination date and the date on which the policy revisions were implemented. While early returns on the IRAV policy suggest that revisions will produce some decreases in the length of stay in PHS, DYS is encouraged to revisit the task of developing a QA procedure for the use of seclusion to ensure it is anchored to specific standards (i.e., What are the agency's expectations regarding the length of stay in PHS? What are the agency's expectations surrounding the use of seclusion as a sanction versus the use of alternatives to seclusion?). Once anchored to clear standards, the mass of QA data regarding PHS and Intervention Seclusion can be more easily interpreted. Setting specific targets will permit the agency to evaluate its facilities' performance in context and will permit the agency to substantiate, with objective data, whether it has complied with the requirements of this provision. Historically, the Monitor has interpreted data related to seclusion—moving forward, the DYS should assume this responsibility. The Monitor is available to provide technical assistance on setting standards, collecting, analyzing, and interpreting data, if desired. *Seclusion among Youth on the Progress Units (PU)* As noted in the Introduction, the conditions of confinement on the PU are discussed in a Status Report that is attached to this report. Once the State reaches substantial compliance with all of the provisions of the Court Order governing the PU, the use of seclusion on the PU will again be discussed in this section of the report.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop robust Quality Assurance/Quality Improvement processes to determine whether the IRAV and Sanction Grid revisions are properly implemented and whether they have significantly reduced the reliance on isolation to control and respond to youth's behavior. These processes should include:

	a. Standards that indicate the benchmarks against which performance will be measured, which should clearly indicate a preference for non-seclusion based sanctions and methods for de-escalating youth's behavior. b. Audit methodologies; c. Analysis and interpretation of data; d. Development of a Quality Improvement Plan for each area in which performance deficits are identified. 2. Once the Consent Order for the PROGRESS Unit has been satisfied, maintain the current procedures for out-of-room time on the PROGRESS Unit.
Sources of Information	• Self-assessment data for III.A.3, prepared at my request • Monthly Superintendent's Reports, October 2012 through March 2013 • Consultation with Steve Martin, subject matter expert for *S.H. v. Reed et al.*, and various DYS personnel regarding modifications to IRAV and Sanctions Grid • AMS Seclusion Log, February and March 2013

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 October 2012 and March 2013, a total of 50 investigations were completed related to the topics covered by this provision (37 of these were completed by facility-based investigators and 13 were completed by the CIO). Of these, 7 of the local investigations (19%) were substantiated and 11 of the CIO investigations were substantiated (85%), or 36% overall. As noted in previous Monitors' Reports, the low proportion of substantiated allegations is likely due to the poor quality of the local investigations. Among the substantiated investigations: • 9 (50%) involved an unsanctioned restraint technique (e.g., elbow in the youth's face; hooking an arm around the youth's neck; unsafe take down; laying on a youth who was prone; dragging a youth by his shirt); • 3 (17%) involved an inappropriate comment or behavior (e.g., a comment about a youth's mother; using gang-related hand signals; backing into a youth's room in a suggestive manner); • 2 (11%) involved physical abuse or an abusive practice (e.g., exchanging punches with a youth; cutting off a youth's water and vent); and • 4 (22%) involved improper procedures (e.g., failing to use the handheld camera and notifying about a youth's refusal to remove restraints; failure to report a fight or use of force; leaving post without relief; bringing in a personal cell phone; inappropriate contact with youth via FaceBook). *Quality Assurance* The CIO conducts an audit of the facility's investigations every four months. The audit process was recently enhanced to include a variety of performance indicators. The most recent CIO report, covering September through December 2012, uses these performance indicators to assess the quality of a random sample of 12 local investigations. Several

	performance indicators were met: • 90% appropriately documented the allegation • 80% included a narrative summary of each interview • 90% used correct terminology in the conclusion • 100% included all attachments • All of the investigators had been trained • 83% of the investigations were properly scanned into AMS • 100% issued Notification Letters to youth whose allegations were reported via the Grievance System. However, the CIO report identified that a large number of performance indicators, arguably the more substantive of the lot and those that reflect the quality of the investigation, were not met: • Only 40% included a review of all relevant documents and video; • Only 10% were started in a timely manner; • Only 40% interviewed all relevant staff and youth; • Only 60% notified staff of their status (as a witness or the subject) during the interview; • Only 50% noted the time and date of the interview; • Only 30% asked all of the necessary questions required to respond to the allegation; • Only 60% came to a conclusion that was supported by the evidence; • Only 17% met all required timelines. These results mirror the Monitor's and, obviously, create serious concern about the ability of the investigation process undertaken at the facility level to adequately protect youth from harm at the hands of staff. On a positive note, however, the revised audit methodology and performance indicators add a great deal of integrity to the investigation process. Hopefully, the CIO's new process will catalyze much needed improvements to the local investigation protocol and product.
Steps Taken to Assess Compliance	*Chief Inspectors Office (CIO) Investigations* Timeliness. Of the 13 investigations reviewed, 12 (92%) 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). At the time of the Monitor's site visit, the CIO also had 2 pending investigations, neither of which had yet reached their due dates. The timeliness of CIO investigations has improved significantly since the previous Monitor's report. Quality. Each of the 13 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

	peripheral 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. *Local Investigations* Timeliness. Of the 37 investigations completed by Scioto staff during the current monitoring period, only 18 (49%) were completed within the timelines prescribed by policy. While this is an improvement over the last monitoring period, where only 23% were on-time, the timeliness of investigations conducted at the facility level is a major concern. The remaining 19 investigations (51%) were late (an average of 61 calendar days!). In addition, at the time of the Monitor's site visit, 2 local investigations were pending and both were significantly overdue. As discussed in each of the previous Monitor's Reports, the investigation process is a critical feature of the State's ability to protect youth from harm. The continued and widespread delays in completing investigations have deleterious consequences across the board: • Delays greatly compromise the ability to accurately assess the veracity of the allegation; • Delays prevent guilty staff from receiving necessary re-training, discipline or termination, which perpetuates the risk to youth; • Delays unfairly stress innocent staff who may be placed on modified duty awaiting the outcome of the investigation; and • Delays exacerbate the already prevalent sense among youth that the facility does not take their complaints seriously or that "nothing will be done" about the concerns they have regarding their treatment. This problem has been at the forefront of the Monitor's concerns since the inception of this case. Quality. Even after the Monitor downgraded the compliance level for this provision in the 2nd Monitor's Report and commented extensively on the various inadequacies identified among the reports for the past two monitoring periods, the quality of the investigations has not improved and remains far below professional standards. As in the previous monitoring period, the Monitor provided detailed feedback on each of the 37 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. Among the most serious problems: • 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. • 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. The absence of follow-up questions from many of the investigators suggested that the investigators were simply going through the motions without a particular drive to determine what actually occurred. • 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, sequence was off, which meant that the investigator could not conduct the subsequent interviews effectively. • The investigator should follow-up on peripheral issues that emerge, such as staff witnesses' failure to report misconduct that they observe or failing to write an accurate incident report. • The basis for the conclusions must be clearly articulated and must rest upon facts that were gathered during the investigation. Many of the investigators did not write coherent narratives and did not summarize the facts that supported the conclusion, and did not explain why they discounted facts that didn't fit. In one case (#5501120122), the Monitor had the opportunity to review videotaped footage of the incident in question. The investigator left out many relevant details, did not confront witnesses with various omissions and contradictions in their written statements, and ultimately came to a conclusion that the allegation was not substantiated, despite, in the Monitor's opinion, rather clear evidence that the subject of the investigation used excessive/improper force. The Monitor strongly recommends that the CIO re-open this case and re-examine the evidence. One wonders how often this occurs—that the investigation is so shoddily done that true allegations do not get substantiated. It is worth noting that these same problems were articulated in the previous two Monitors' Reports, and more recently, by the CIO's Quality Assurance process. The shoddy investigation protocol is insufficient to produce accurate findings of an allegation's veracity and, as a result, places youth at significant risk of harm. When an investigation fails to substantiate a true allegation: • Youth lose faith in the processes designed to protect them (i.e.,

	"the grievance process doesn't work") and may be even less likely to report mistreatment in the future; • Staff are not held accountable and thus are not subjected to the retraining or discipline designed to modify their behavior, which increases the likelihood they will repeat the behavior in the future; • A culture in which staff behave with impunity and believe that "nothing will happen" if a youth reports mistreatment is allowed to perpetuate, which creates a risk that staff will continue to violate the boundaries of acceptable behavior because they do not fear the consequences. The State has made no progress 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. 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 a local investigation and that this responsibility is assigned only to individuals who have demonstrated that they have the requisite skill set. In a conference call between DYS, the DOJ, and the Monitor just prior to this report being issued, DYS agreed to pursue this strategy, if funding permits. 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 local investigation process is a major contributing factor to this problem. *The lack of progress in this area suggests that additional oversight may be necessary. The Monitor recommends that the DYS create a specific Corrective Action Plan/Quality Improvement Plan (perhaps via the Quality Assurance process that the CIO has recently implemented) to determine the underlying causes of the delays and poor quality products, and to enact specific strategies to target each of the underlying factors in order to significantly improve performance in this area. The Monitor will also request copies of all completed local investigations on a monthly basis so*

	that more frequent status reports can be made to the Parties and the Court.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Reduce the number of individuals authorized to conduct local 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 misconduct by staff. The investigations must reflect timely, comprehensive interviews with all key witnesses, must address peripheral issues (e.g., witnesses' failure to report) 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 investigate allegations of all types.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.5, prepared at my request • "Scioto Juvenile Correctional Facility Coaching and Monitoring Report," by the Chief Inspector's Office, January 2013 • Log, "Investigation Tracking Log, October 2012 through March 2013" • Email communication with J. Fears, CIO, and C. Price, Scioto Correctional Facility, to verify dates of submission of various reports • Review of 13 CIO investigations completed since October 2012 (100% of total) • Review of 37 investigations conducted by Scioto staff since October 2012 (100% of total) • Conference call with Ohio Attorney General's office, DYS Chiefs of Staff, Department of Justice and the Monitor, May 29, 2013.

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	The previous Monitor's Report noted that the Scioto Grievance Coordinator hired in May 2012 had largely resolved the systemic deficiencies with the process. *Quality Assurance* As before, the CIO reviews all grievances on an on-going basis. If the grievance response includes all the necessary actions and documentation, it is "closed" by the CIO. If additional documentation or information is needed, "follow-up action" is requested. Once the grievance coordinator provides the necessary information, the grievance is then closed. [For statistical purposes, "follow-up action" is a fluid status and it can only provide a snapshot of the grievance process on any given day.] If the CIO finds that the resolution of the grievance is at odds with facility procedure, "corrective action" is required and the grievance coordinator must revisit the issue with the youth and explain how the grievance was resolved in error. Only 4 of 142 grievances (3%) required corrective action during the current monitoring period: • A grievance was marked "closed by investigation," but the CIO investigated a different part of the issue (fight) and not what was the substance of the grievance (commissary). The Grievance Coordinator corrected the notification letter and also refunded the youth's commissary funds. • A youth complained that the clean clothing still smelled. The Grievance Coordinator didn't actually smell the clothing and the UM had indicated there had been problems with the unit's dryer. The grievance coordinator was encouraged to conduct a broader inquiry should a similar complaint occur in the future. • A youth alleged that a staff called her a "dumb ass." The staff was never asked to make a statement. Upon re-opening the issue at the request of the CIO, the staff refused to make a statement, so the matter was referred for investigation. • A youth alleged physical mistreatment during a restraint. The matter should have been immediately referred for investigation, but instead the grievance coordinator took additional steps to investigate the matter on his own. The CIO admonished him from doing so in the future. The Grievance Coordinator also prepares a monthly report for review by the CIO, and grievance data (number and type) are part of the weekly Management by Measurement (MBM) data that the facility

	Superintendent receives. In addition to this on-going Quality Assurance, the CIO also audits the grievance process every four months. This process includes observations of the interaction between the grievance coordinator and youth; visual verification that the grievance boxes and necessary supplies are available to youth; and checks to ensure that the general procedures are in place. Scioto's most recent QA audit covered October 2012 through January 2013. The auditor reported that the grievance coordinator knew the youth and the youth knew him; comprehensive monthly reports were being produced; and all supplies were accessible. In addition, a random sample of 10 grievances was reviewed to determine their compliance with policy. In all cases, the grievance coordinator met with the youth face-to-face, medical issues and abuse allegations were handled per policy, follow-up occurred as needed, and all youth were given a copy of the grievance and its resolution. The only point of development was to ensure that the new lesson plan for Orientation, created by the CIO to standardize the information presented across the facilities, was used. Clearly, the grievance process benefits from a great deal of oversight to ensure that grievances are resolved timely and that youth are provided with a solid mechanism to voice their concerns and to ensure they are treated fairly. Other performance indicators continued to improve throughout the current monitoring period, as compared to the systemic problems noted in previous reports. In Q4 2012 (October-December), 100% of the grievances were resolved within required timelines, and in Q1 2013 (January-March), 98% of grievances were resolved timely. In terms of substance, in Q4 2012, 32 of 80 (40%) grievances required follow-up action, generally, questions about how the incident was coded or to clarify how the issue was framed. As noted above, "follow-up required" is a status that can be quickly remediated with additional information or documentation. The CIO did not report this statistic for Q1 2013. A total of 80 grievances were submitted in Q4 2012 and 62 were submitted in Q1 2013. The rate of grievances per youth has remained stable for quite some time, save for a spike in Q2 2012. The youth's chief concerns included complaints about staff's decisions (18% of the 142 grievances submitted), program concerns (10%), physical abuse (9%), verbal abuse (8%), and medical concerns (8%). More specifically, examples include: • *Alleged Verbal Abuse*: "staff threatened to extend my stay," "staff called me 'a joke'," "social worker has an attitude," "staff said 'Wake your fat ass up!'," "staff threatened to write me up," "staff called me a 'fag' and said he'd get my sister pregnant," " social worker made sexual comments to me," and "YS is bragging

	that he's going to fight me." [These last two were referred for investigation.] • *Alleged Physical Abuse*: "staff put her hand on my back," "staff smacked my hand when I grabbed a tray," " staff pushed me when I hit him with a basketball," "staff squeezed my wrist to get a bag of chips," "staff pulled hard on my gators," "staff choked me and banged my head on the wall," "staff hit me on the neck, lays hands on us a lot." [The last four were referred for investigation.] In terms of the grievances' resolution, 69% had no merit, 20% had merit, 7% were referred for investigation, and 4% were pending at the time of the CIO's report. Not only does the DYS have a robust system for monitoring the grievance process, but the results of those audits reveal fidelity to the design and a clear commitment to ensure that youth have ready access to a confidential grievance process.
Steps Taken to Assess Compliance	The DYS has done such an exceptional job of auditing its grievance process that the Monitor had little to add. *Youth Survey* The CIO re-administered its Youth Survey in Q4 2012. The results largely paralleled the previous survey—30% reported they'd been told they could not use the grievance process to report staff misconduct, 39% reported they were treated "differently" after filing a grievance, and 62% said that staff told them nothing would happen if they filed a grievance. On the surface these results would appear to conflict with what the Monitor and the DOJ Attorney heard in their interviews with youth, who listed the grievance process among the facility's strengths, and reported that they knew and appreciated the Grievance Coordinator's accessibility and approach to dealing with their issues. However, the responses to the CIO's survey suggest that the youth's concerns about the process lie not with the Grievance Coordinator but with the direct care staff's attempts to undermine the process. In response to this survey, the Facility Superintendent has attended Roll Call for each shift and reinforced the importance of supporting, and warned against undermining, the grievance process. *Notification to Youth about the Outcome of Investigations* 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 8 investigations were closed that were initiated via a youth grievance. Letters to youth notifying them of the outcome of the investigation were presented to all youth (100%). However, as noted in the previous Monitor's Report, although letters were sent out in every case, some of the cases had a significant delay between the date the investigation was completed and the day the letter was drafted. The table below summarizes the key dates for each case:

Timeliness of Youth Notification Letters

Investigation #	Date Case Closed	Date of Letter (business days from completion)	Date Signed by Youth (business days from letter being sent)
5501120080	10/15/12	11/21/12 (22 days)	11/26/12 (3 days)
5501120098	10/11/12	11/6/12 (17 days)	11/7/12 (1 day)
1001120087 (youth 1)	10/13/12	11/6/12 (17 days)	11/6/12 (~)
1001120087 (youth 2)	10/13/12	11/6/12 (17 days)	11/6/12 (~)
5501120105	10/29/12**	11/6/12 (6 days)	11/6/12 (~)
5501120110	11/6/12**	11/15/12 (7 days)	11/15/12 (~)
5501120117	11/30/12**	12/6/12 (4 days)	12/7/12 (1 day)
5501120132	1/4/12	1/23/12 (13 days)	2/8/12 (12 days)

**These investigations did not have a closure date on the log submitted to the Monitor, so the date the investigation was completed was used. Given that the closure occurs after the report is submitted, the closure date would not change the outcome of this analysis.

Current DYS policy does not set a specific timeline for sending out notification letters, although an upcoming revision will require the letters to be sent within 5 or 10 business days. Using 10 business days from the date of case closure as an outside limit, the table above illustrates that letters are generally not sent out timely. Across the 8 investigations, only 3 were sent out timely (38%; range 4 to 22 business days; average 13 business days). It is also worth noting that the Notification Letter for one of these investigations (1101120087) erroneously indicated that the allegation was unsubstantiated, when in fact, it was found to be true. Youth generally sign the Notification Letters in a timely manner. Although the situation did not occur during the current monitoring period, in the past, DYS has delivered the Notification Letters to youth who were released prior to the investigation's completion.

Thus, youth are being notified of the outcome of the investigations, but the notification needs to be 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. The CIO plans to monitor the timeliness of the Notification Letters in the future, which should accelerate progress toward compliance.
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 • Q4 2012 and Q1 2013 Grievance Audits completed by the Chief Inspector's Office • Grievance Monthly Reports, October 2012 through March 2013 • AMS Grievance Summary for grievances submitted October 2012 through March 2012 • List of Grievances requiring "follow-up action" and the substance of that action, Q1 2013 • List of Grievances requiring "corrective action" and the substance of that action, Q4 2012 and Q1 2013 • List of completed investigations that were triggered by a grievance, October 2012 through March 2013 • Copies of Youth notification letters for grievances referred for investigation, October 2012 though March 2013

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. The 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 has developed 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 most recent QA report, issued February 2013, found that Scioto had yet to implement the new lesson plan, and were still using they one they had developed internally. 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, October 2012 through March 2013, 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	The State continues to conduct rigorous audits of facility records to ensure that the Orientation to the grievance process is delivered upon admission. All of the underlying documentation submitted to the Monitor verified the reported results—that 100% of the sample received a proper introduction to the grievance process.
Recommendations	The State remains 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

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* Via the *S.H.* litigation, the DYS developed and implemented a Quality Assurance Protocol for structured programming during the current monitoring period. Over the years, DYS has struggled to assemble and interpret the large volume of data regarding program participation. The QA protocol is a tremendous breakthrough. DYS developed a full set of standards from which performance can be measured. Given how many different activities comprise Structured Programming, the area was broken into component parts. *Programming* includes the Managing Anger and Violence (MAV) groups, Victim Awareness groups and the Phoenix Program. Standards for this component include: • All youth admitted to DYS shall participate in all 50 Core B (MAV) sessions, until completed or released. A minimum of 12 MAV groups shall be facilitated monthly by staff on each unit. Unless attending a priority treatment program, youth shall attend no less than 10 MAV sessions per month until completion. • Youth identified at Intake as needing victim awareness shall attend and complete the Victim Awareness Education Program prior to release from the facility. A minimum of 4 Victim Awareness sessions shall be facilitated monthly by qualified staff. Until completion, identified youth shall attend no less than 4 Victim Awareness sessions per month. Due to the Victim Awareness Education Program being a closed group, a waiting list shall be developed and available. • If appropriate, youth identified as active Security Threat Group (STG) members upon admission, or at any point during their

	incarceration, shall participate in the Phoenix Program. A minimum of 4 Phoenix Program sessions shall be facilitated monthly by qualified staff. Until completion, identified youth shall attend no less than 4 Phoenix sessions per month. Due to the Phoenix Program being a closed group, a waiting list shall be developed and available. With regard to *Recreation and Community Service*, the following standard was developed: • Youth shall receive at least one hour of large muscle activity per day. The program involves a wide variety of physical activities and intends to produce physical skill building and personal fitness. At least 70% of youth are expected to participate in the Presidential Fitness Test each quarter. Recreation staff provide input into youth's treatment reviews by attending the IDT meetings each week. Total community service hours should equal twice the ADP. With regard to *Religious and Volunteer Programming*, the following standard was developed: • In order to reduce idleness and advance the goal of rehabilitation, the facility maintains an array of religious and volunteer-led programing for youth. Each facility will provide a minimum of 350 hours of volunteer-led programming each month. The Chaplain at each facility will offer, at a minimum, one congregate worship service each week for eligible youth. Together, these five Standards cover the full range of structured programming for youth and provide clear, measurable goals for youth's participation. Using these standards and a rigorous methodology, DYS conducted an audit of the facility's performance in March 2013. The findings were discouraging: • *Programming* results were mixed. With regard to MAV, the girls' units met the standard related to the groups, but did not meet the threshold for individual participation rates. None of the boys' units met the standards for groups, and only one youth attended the minimum number of MAV sessions. The facility met the standard related to the Phoenix Program, but did not meet the standard related to Victim Awareness programming. • With regard to *Recreation and Community Service*, all of the units held the required number of recreation sessions, and all but 1 had sufficient attendance rates. Participation rates were high in 6 of the 7 units (and the other unit only missed the benchmark by 2 percentage points). The President's Physical Fitness Challenge is not scheduled until June 2013, so participation could not be audited. Only 12% of youth in seclusion participated in recreation. A lack of detail in unit

	records prevented the auditor from assessing GAT presence/input at IDT meetings. The facility did meet the standard related to Community Service, with each youth given at least two opportunities to participate per month. • With regard to *Religious and Volunteer-Led* programming, the facility exceeded the requirements with 460 hours of Volunteer Programming, although the auditors did not collect the required information on youth participation levels. The facility also far exceeded the requirements around Congregate Services, with 24 services offered. While the audit results are concerning, the fact that DYS is now capable of auditing and reporting on the quality of youth programming in an integrated and coherent fashion is a tremendous accomplishment. Hopefully, the innovations surrounding the auditing process will lead to substantive Quality Improvement Plans that will accelerate the facility's movement toward substantial compliance. Recently, the facility changed the location where groups (MAV, Victim Awareness, Phoenix, etc.) are held to ensure that groups occur as scheduled. Due to the facility's low population, the Annex of the school building has sufficient capacity to house groups for the general population in the afternoons and on weekends. More consistent oversight by the Unit Managers, improved supervision by the Youth Specialists and focused attention from the Deputy who oversees programming should ameliorate the problems related to scheduling revealed by the QA audit. Problems related to documentation and data entry were also identified during the audit. *Programming for Graduates* During the previous monitoring period, the facility made significant progress in developing programming for youth who have graduated from high school or obtained their GED. These programs have all been sustained. Graduates are engaged 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 Finance, Entrepreneurship, and Accounting. Courses are offered on a rotating basis and classes are held twice per week for 4.5 hours. 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 is paid $0.90 per hour. 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 DYS' new Quality Assurance protocol provides all of the data necessary to determine whether the State is in substantial compliance with this part of the provision—the Monitor did not need to conduct any subsequent audits. As noted above, the March 2013 audit revealed some serious performance deficits that must be rectified in order to reach substantial compliance with this provision. Once the scheduling and documentation/data entry issues are addressed, another audit should be conducted to determine whether problems remain. The Monitor will then validate/confirm the QA audit's findings with her subsequent audits. Although additional data collection and analysis was not required to assess compliance, interviews with staff and the Deputy responsible for programming suggested that the facility continues to evolve, pushing forward to ensure that youth's idle time is limited. A Game Room and a Small Muscle Activity area equipped with board games, video games, foosball, Ping-Pong, etc. were created. Some of the units have time scheduled into these rooms, while other youth are permitted to purchase admission using SBBMS points. In addition, the facility is looking to bolster the volunteer programming available to males in the general population. [During the time that Scioto was a male reception center, the volunteer programs catered to the female population because of their longer length of stays.] *Programming for Graduates* At the time of the Monitor's site visit, 10 youth housed at Scioto had graduated from High School or obtained a GED. Of these, 90% of those eligible had jobs (one youth is on the PU and is not eligible to have a job—the UM is responsible for developing a daily schedule for all

	graduate youth; the other youth did not want to work). Seven of the 10 youth were enrolled in the Accounting course (those not attending either arrived at Scioto after the class began, or were not accepted to the program). A female youth with very high ACT scores was also taking on-line classes at Columbus State. Finally, a new Job Readiness course is available to graduate boys in the general population (all were attending). In the near future, an 11-week Barbering class that offers certification will be available as well. Attendance records for the graduate academic program revealed that a total of 14 youth participated in at least one of the four courses offered during the current monitoring period. Youth attendance was extremely high, with few class periods missed by any youth. Occasionally, youth were removed from the classes due to on-going, serious behavior issues that disrupted the learning environment. The facility keeps monthly data showing the proportion of graduates who are employed. Throughout the monitoring period, the rate of employment for male graduates averaged 86% (range 64% to 100%) and the rate of employment for female graduates averaged 94% (range 66% to 100%). Each month, the facility had a surplus of available jobs and clearly has the capacity to accommodate more graduates with jobs, if needed. When interviewed, graduate youth reported there was "more to do at the facility than there used to be," although also noted that they had more free time than the non-graduate youth when their jobs ended for the day. Overall, the facility continues to operate a solid program for graduates that constructively occupies the portion of the day that non-graduate youth spend in school. *PROGRESS Unit (PU)* Improvements to the programming schedule for youth housed on the PU are discussed in the attached Status Report. Once DYS achieves substantial compliance with the Consent Order, information on programming for youth on the PU will again be reported here.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Create a Quality Improvement Plan to improve compliance with QA standards related to all three components of Structured Programming. Implement strategies directed at each of the underlying causes of the failure to meet performance standards. Track the effectiveness of these strategies on a monthly basis until the problems are rectified. 2. Once the Consent Order related to the PROGRESS Unit has been satisfied, continue to implement structured programming opportunities for youth housed on the PROGRESS Unit, as

	required by this provision.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.1, prepared at my request • Interview with Deputy Superintendent for Programming • Quality Assurance audit for Structured Programming, March 2013 • Work schedules for graduates housed at Scioto as of October 1, 2012 • Course attendance records for all post-secondary courses held since October 1, 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	Substantial 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 October 2012 and March 2013, approximately 300 youth were admitted to the facility; 10%, or 30 youth, were included in the audit. Each month, the audits found that 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* With the update of the Youth Handbook and appropriate response to grievances pertaining to religious freedom, the DYS satisfied the requirements of this provision during the previous monitoring period. During the current monitoring period, three youth submitted grievances pertaining to religious freedom. Two of these were found to have no merit: • A youth requested information about Wicca. He had already received all of the information, and had met with both the librarian and the Chaplain. • A youth complained that he'd received a YBIR for wearing a kufi. The YBIR was issued because the kufi did not belong to the youth.

	One of the grievances was found to have merit: • A youth did not want to shave because it violated his religious beliefs. [The youth is Muslim.] His request was granted. The Youth Handbook clearly articulates that youth are free to practice their religion of choice and the facility continues to demonstrate 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. SOP 303.01.07 "Unit PROGRESS" 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. Both the policy and handbook (now final and signed into effect!) are the subject of the Consent Order covering the Unit's operation and thus are not discussed here. However, given that some youth enter the facility via the PU, their timely orientation is discussed in this report. During the current monitoring period, 14 youth were admitted to the PU (some youth had multiple admissions, but are counted separately given that they must receive an orientation on each admission). Signed "Handbook Signature Sheets" were submitted for all youth and verified that all youth received a timely Orientation (usually on the same day of transfer, occasionally on the next day).
Recommendations	The State is in substantial compliance with this provision.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.2, prepared at my request • Intake Audit Report, October 2012 through March 2013 • Scioto Youth Handbook, last modified March 16, 2012 • Grievances related to religious accommodation (n=3), submitted between October 2012 and March 2013 • Admission dates and orientation records for youth admitted to the PROGRESS Unit since October 1, 2012

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) does not conduct a self-assessment for the level of medical and dental care provided at SJCF. However, there continues to be improvement in their quality assurance processes, which in essence completes the task of self-assessment for the purpose of this report. Also, the facility was accredited through the American Correctional Association (ACA) in September 2012 to include health care standards.
Steps Taken to Assess Compliance	An onsite visit was conducted at the Scioto Juvenile Correctional Facility on April 23-25, 2013. It was this monitor's third visit to the facility. All previous reviews of health information and other related documents had been conducted off site from records provided by ODYS. All living units where youth were being housed were visited. The Hunter and Carver Units had been closed. There has been a continuing decrease in the facility's population over the last several visits, down to 37 males and 17 females on this site visit. The location of the sick call health request boxes and availability of the health request slips were observed on each living unit. Slips were not in place outside the box on two units. Youth were interviewed on the units as to how to access health services and if they had any complaints regarding their medical care. All the youth I interviewed knew the correct process to obtain health services and had no complaints about the health services. There was one complaint made to a member of the team by one of the females that she had been ignored by the medical staff while in labor. The food service area was toured and the medication room located there observed. The satellite clinics for Buckeye have not been completed. The population housed on those Progress units has been significantly reduced. The main clinic was still found to be adequate, with appropriate space, medical supplies and equipment for medical and dental care of the youth. A review of seven youth health records housed at the Scioto Facility was conducted. This included three females and four males. 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; Youth Injury and Assessment Forms; Youth Health Requests and medical staff responses; Progress Notes including seclusion checks and Physician Orders were identified in each health record. All health records documented timely completion of intake assessments. Nurse screening health appraisals were completed on the same day of admission. Physical examinations, including gynecological exams for females were completed the following day. Problem lists were inclusive of medical, mental health and dental conditions. Growth charts were present in the health records of all youth. All youth allergies were noted on their health record. There was documentation of admission labs being drawn with results available all within a week. Specialized laboratory testing was documented such as Strep testing, Hemoglobin A1C for diabetes, and Beta HCG for pregnancy confirmation. STD (Gonorrhea and Chlamydia) urine screening test results were documented in all records. One youth identified in the screening process to be positive for a Chlamydia STD received treatment. Immunization records were present in all records reviewed. HPV vaccine is now being administered to youth, male and female (43 in the last quarter). The previous back order on the HPV vaccine through the Federal Vaccines for Children Program has been resolved with only one youth of seven reviewed not receiving that vaccine. All youth reviewed received tuberculosis screening with documented results. One youth with a previous history of a positive TB skin test appropriately received a chest x-ray upon admission, rather than another skin test being administered. Dental examinations were completed within three days of admission with instruction given on oral hygiene and prophylaxis completed. Dental treatment was provided as a result of the dental examination or as a result of a health request in a timely manner. Two long term youth were recalled for routine dental care annually. The latest recommendation from the American Dental Association is for dental prophylaxis to be completed every 6 months. Medication administration records (MAR) and physician orders were also reviewed for accuracy and medication compliance. Nurses are documenting medication administration as well as when youth refuse medications. In two cases, the MAR was also utilized to document blood pressure checks. Special diets were ordered appropriately.

	Few youth with chronic medical conditions were housed at Scioto. Of the records reviewed, there was one diabetic and two hypertensive youth housed at Scioto. All received appropriate assessments and treatment plans. The diabetic youth that also had a history of asthma, received a special diet, proper medication management, blood glucose monitoring, appropriate laboratory testing, and ophthalmology and endocrine specialty consults. One youth was pregnant when admitted on 11/2/12 to the facility and delivered during her stay. Her obstetrical care provided during her stay was reviewed based on her statement to a member of the monitoring team that her complaint of labor pain was ignored by medical staff. She had been seen by Dr. Stein at the facility and received 9 regular visits to Dr. Koffler, Obstetrician for Central Ohio OBGYN, the last of which was the day before she delivered on 4/17/13. At that time there was no indication of her being in active labor at 39 weeks pregnant. On 4/18/13, youth began complaining of back and stomach pain at 7:15 AM. She was seen by medical staff at that time and again at 10:05 AM complaining of pain and wanting a tranquilizer. Medical explained the labor process and encouraged walking and fluid intake. Contractions were irregular at that time. Youth was brought from school on the golf cart to medical and seen at 12:47 PM with continuing irregular contractions, having vomited a small amount after eating lunch. Her baby's heart rate was documented on the exam. Youth was instructed to return to the unit and rest with increased fluids. The facility nurse contacted Dr. Koffler's office and informed their nurse practitioner of the situation and asked for any further instructions. At 3:15 PM, medical was called and unit staff reported passage of the mucous plug. Youth was assessed in medical with regular contractions 2-3 minutes apart and fetal heart tones present. Youth was then transported to Grady Memorial Hospital and delivered without complications at 5:15 PM, progressing faster than usual for a first delivery. Three of the seven youth records reviewed had at least one mental health diagnosis. Mental health diagnoses have continued to be consistently listed on the problem list along with the medical diagnoses. None of the psychological documentation for the youth in included in the health record. When nurses made seclusion checks, they were documented in the progress notes. Logs were posted on the unit doors. There appears to be some reduction in the use of room seclusion based on documentation in the health record. One youth housed on the Progress Unit averaged about four episodes of room seclusion a month between November 13th and February 1st. For the remainder of February and March there were still about the same number of room seclusions, but the number of days in each episode grew shorter. The medical progress notes state "seclusion check" and now include details of the youth's health status in SOAP format. This is an improvement over the last site visit.

	Documentation on the Youth injury and Assessment Reports were reviewed for those included in the seven health records. The documentation provided by nursing staff for youth assessed for injuries has significantly improved. The Nurse Manager, Ms. Vickie Donohue has continued to monitor these assessments through the continuous quality improvement (CQI) review process. There was one Youth Injury and Assessment form reviewed secondary to an allegation of staff abuse. Medical was called on 3/23/13 to the Cedar Unit to assess youth after he had assaulted a staff member. At 5:55 PM, a visual check was made by the nurse and no injuries noted. The youth had no complaints and was told he would be further assessed in the exam room when he calmed down. At approximately 6:15 PM, youth was escorted by unit staff cuffed from behind to the exam room. No visible injuries to the face or hands were noted. Youth denied having any injuries twice to medical staff. Youth was taken to Sycamore Unit by staff. Youth requested to see nurse and was taken to exam room on unit at approximately 6:40 PM. Youth then made an allegation to the nurse that staff beat him up. The medical exam at that time documented that the left side of his face was swollen and tender, his left forearm and wrist were swollen with deformity and his left ankle swollen. He complained of pain upon touching his face, arm and wrist. He had visual complaints that had resolved by the time of the exam. Internal Continuous Quality Improvement (CQI) documents were reviewed that were provided by the Scioto nurse manager. The nurse manager and staff nurses continue to participate in the CQI process. The Medication Administration Record CQI document for January 2013 averaged 87% based on the 10 compliance indicators reviewed. The CQI Intra-system Transfer tool of January 2013 showed 100% compliance for nine of ten quality indicators with 75% for one indicators regarding documentation in the progress notes. Four charts in January and five charts in April were selected for a CQI audit of the processing of specialty consults. There was 90 -100% compliance for six of nine quality indicators. Low compliance percentages occurred for documentation that a parent or guardian had been notified and with scheduling follow up physician appointments. The nurse health call CQI audit of March 2013 showed 100% compliance on 8 of 10 compliance indicators. Improvement was needed on documenting vital signs on each encounter. The Nurse Charting Review CQI audit of March 3013 showed 9 of 10 quality indicators at 100% and one at 90%. Vital signs at the time of each encounter were reviewed on March 5, 2013. The documentation of vital signs CQI audit showed 100% compliance with the 4 quality indicators. The CQI audit tool for Laboratory and Diagnostic Tests was reviewed for January and March 2013. The two lowest compliance indicators at 60% were for lack of documentation that youth were informed of normal or abnormal test results. Since the last visit, the CQI audits for completion of

	the Youth Injury Assessment Form (YIAF) have been reviewed monthly since January 2013 due to deficiencies identified from the previous report. Over those months the documentation and compliance indicators continued to improve. Lack of documentation of youth education was noted as a particular area of weakness. The last audit of 3/29/13 had 100% compliance in 9 of 10 quality indicators with 90% in that one indicator. This outcome demonstrates the true benefit of a self-auditing process. Medical staff also identified through this process the need to modify the CQI instrument to monitor discharge planning. Medical findings were discussed with Dr. John Brady, Medical Director and Scioto Nurse Manager, Vickie Donohue.
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. Continue to limit time of youth in seclusion with documentation of health status during segregation. 3. Continue to improve Quality Assurance (QA) activities to include some additional quality outcome indicators. 4. Continue accreditation through the American Correctional Association as an external auditing process.
Sources of Information	• Site visit tour; Review of seven youth health records: ID # 218418, 217757, 218277, 218393, 217113, 218312, 216642; 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) does not conduct a self-assessment for the level of medical and dental care provided at SJCF. However the health records are being reviewed as a part of the CQI process.
Steps Taken to Assess Compliance	Review of seven youth health records. There were no new Health Policies and Procedures or Standard Operating Procedures (SOP) completed by ODYS since the last visit. Three of seven youth had been transferred from other facilities. These youth health records contained health information from the transferring facility. The offense information was not present in the health records reviewed at this visit. The health record is still incomplete, due to the psychological and counseling notes being housed separately on the housing units. The RFP awarded to eClinical Works for an electronic health record (EHR) through the Ohio Department of Administrative Services and the Office of Information Technology (OIT) was in the implementation phase during this visit. The eClinical Works EHR correctional module has been used successfully in other correctional settings. I attended the presentation to demonstrate how the adult Department of Rehabilitation and Correction (DRC) had structured the use of the EHR in their system. In attendance were Dr. John Bradley (Medical Director), Jacqueline Carter (Nursing Director) and other DYS central office health staff in order to review the system and determine how best to utilize it to meet the needs of DYS. Certified trainers are being used to train certified users for current field testing in DRC. The same process will be required in order to adequately train DYS medical staff in the use of the system. 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, Immunization database, Franklin Medical Center and OSU Hospital records. Of great significance, the youth mental health records will interface with the new EHR. The eClinical Works electronic health record being established will facilitate the sharing of the mental health and medical information into one combined health record. The system is web based will be able to interface with community providers and pharmacies and improve continuity of health care for youth

	upon release.
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 and counselors through implementation of eClinical Works EHR. 2. ODYS medical management staff should continue to be intimately involved in the process of customization of the EHR to be relevant to youth medical services.
Sources of Information	• Site visit tour; Review of seven youth health records: ID # 218418, 217757, 218277, 218393, 217113, 218312, and 216642. • Presentation on eClinical Works electronic health record

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) does not conduct a self-assessment for the level of medical and dental care provided at SJCF.
Steps Taken to Assess Compliance	Health Request drop boxes were present on all the units where youth were housed. Health Request boxes were present in the cafeteria and in the school. Of the 7 housing units toured, slips were outside the boxes and readily available to youth on all but 2 units. On one unit, the staff immediately located the slips and refilled the box ; on the other, staff could not locate the blank health request slips. One youth when questioned on that same unit stated that the slips were not always available. This is an acceptable rate of error. Youth were interviewed on the units as to how to access confidential health services. Youth interviewed knew where the boxes were located and all could verbalize how to gain access to health services. Nurse Health Requests submitted by the youth were reviewed in 7 health records. Most health requests were related to skin complaints such as acne and rashes, musculoskeletal pains and dental complaints. Each Health Request was reviewed and traced back to a corresponding progress note to determine if the complaint had been addressed. Health requests included in these health records were responded to adequately and documented by medical staff 100% of the time. In all cases, the requests had been adequately assessed and treated in a timely manner by registered nursing staff, physician or dentist.
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 seven youth health records: ID #218418, 217757, 218277, 218393, 217113, 218312, and 216642.

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	Substantial Compliance
Self Assessment	This provision pertains to the facility's ability to deliver the special education program. Certain foundations need to be in place—adequate safety, sufficient numbers of qualified teachers, and dependable access to the education program that is not interrupted by disciplinary procedures that remove students from school for long periods of time. The State was asked to comment on each of these issues (summarized here) and to provide quantitative data to demonstrate their level of compliance (analyzed below). *School Safety* Although at times in the past the school was a hotspot for youth violence, changes were made to the way students cycled through the school facility, the number of staff posted in the school buildings, and to the physical features of the classrooms. These modifications, coupled with the stabilizing influence of a highly competent set of school administrators, have transformed the school into a relatively safe environment where learning can occur. Education has also become better integrated with the rest of the facility's programming. The Superintendent, Direct Deputy and Programming Deputy all attend the school's morning meeting, allowing for the free exchange of information across disciplines. Even though the youth violence problem in school has improved, school administrators continue to develop new strategies to improve the school environment and increase student's engagement. A school incentive program was introduced to supplement the SBBMS. When students meet a set of education-related behavioral expectations (e.g., perfect attendance, no YBIRs, no ABC referrals, good hallway movement) and performance measures (e.g., effort in class, complete assignments), they earn tokens (i.e., "apples") that can be used to purchase admission to a Friday assembly along with a variety of snacks and drinks. This program has reportedly improved student behavior and performance in the classroom. *Staffing Issues* Although the teaching roster still has a few vacancies (science, math, special education and substitutes), the facility's low population means that the current complement of staff is sufficient to provide all core

	subjects, vocational courses, and electives without interruption. Students in all of Scioto's programs now have dependable access to the 330 minutes of education required by State law. *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. While youth may be sent back to the unit in emergency situations (i.e., out of control behavior, fights, etc.), the State ceased suspending students in June 2011, relying instead 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. Most youth stay between 1.5 to 2 hours—they may earn 10 minutes off their ABC time for every 30 minutes they spend focused and engaged in their classwork. In the past, staffing 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. The staffing problems have been resolved, and the ABC room has been available on a daily basis for over a year. The number of youth sent to the ABC room during the current monitoring period fluctuated. During the 2nd grading period, 26 youth were referred to the ABC room, as compared to 76 referrals during the 3rd grading period. However, across this same time period, there were 193 and 106 emergency removals (i.e., youth returned directly to the housing units, bypassing the ABC room). These data suggest that youth's classroom behavior is being managed more effectively—teachers are intervening earlier and sending youth to the ABC room rather than sending them directly to the unit. This effort to maintain the youth in the classroom is fully aligned with the intent of this provision. *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). Each morning, the attendance clerk 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 (which rotates throughout the day) delivers the work to each student, and also provides 30-minutes of instruction, four times per day. Classwork for youth on Pre-Hearing Seclusion (PHS) for an act of violence is delivered underneath the youth's door. For most youth, PHS lasts less than 2 days (see the discussion for III.A.3, above). If a youth receives additional seclusion time as a sanction, they are brought out to the table in the dayroom, unless their behavior suggests a risk of violence. The Operations staff makes these determinations, and the assumption is that youth on Intervention Seclusion will be served in the dayroom, unless otherwise indicated. The school's clerical staff and administrators expend significant time and energy reviewing and monitoring Unit Instruction records to ensure compliance. A teacher reviews each youth's folder every afternoon, makes sure the documents are filled out correctly and enters the information in to the database. The attendance officer double checks the paperwork and the entry into the database and files the student's paperwork. On a monthly basis, the Unit Instruction log is compared to the AMS seclusion list by at least two school administrators. Finally, Central Office reviews the information every couple of months and sends written feedback to the facility. Reviews during the current monitoring period found high rates of compliance. *Progress Unit School* As noted in the previous Monitor's Reports, the PROGRESS Unit (PU) school was the site of numerous staff and youth assaults. Enhancements to the direct care staffing levels and the physical "hardening" of the environment (different furniture, bolting down monitors, flex keyboards, etc.) reported in the previous Monitor's Reports have largely solved this problem. While misconduct still occurs among these high-security youth, the environment has settled, teachers are becoming more creative and youth are becoming more engaged in the program. PU students have made important academic achievements (one earned a GED, one earned a diploma, several made the Honor Roll and Merit Roll, and one of the students had the highest GPA on campus). New course offerings (PE for Phase 2 youth and Health for Phase 1 youth) will help to ensure that PU students continue to earn needed credits during their stay on the PU. Overall, the school administrators are vigilant about the school environment and the various barriers that could impede access to the education program. The system of internal review and monitoring is fully capable of identifying and responding to any problems that may arise over time.

Steps Taken to Assess Compliance	*Attendance* Overall school attendance rates are reported every month on the Superintendent's report, and the DYS also provided these data disaggregated by housing unit. Across the six-month monitoring period (October 2012 through March 2013) average unit attendance rates ranged between 83% (Sycamore) and 95% (Allman) with an overall average of 89%. Importantly, only one of the units (Sycamore) was below the 85% benchmark, and only by two percentage points. The attendance rates consistently met or exceeded the 85% threshold across the rest of the housing units. *Unit Instruction* 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 February 1 and March 31, 2013 generated by AMS. First, a random sample of 23 youth with seclusion stays in excess of 48 hours was selected from the AMS list. A surprising number of youth had to be excluded from the analysis because they were in seclusion only over the weekend or on a non-instructional day. [This is positive given that, in these cases, seclusion does not obstruct student's access to school. However, separating in time the sanction from the behavior one is trying to address is not a particularly effective behavior modification strategy.] Once the non-instructional days were filtered out, a sample of 9 youth remained. In each case, students were provided with education services in accordance with DYS Policy #303.01.05 "School Interventions." In most cases, youth received education services on the next school day following their seclusion, though in a couple cases, they received work toward the end of the 48-hour timeline. The Unit Instruction log recorded whether the work was received or declined (most youth accepted the work) and whether the instruction was provided in or out of the room (youth on intervention seclusion were served out of their rooms; youth on pre-hearing seclusion were served in their rooms). Second, for each of the 14 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 2 of the youth (86% compliance), each of whom appeared to be in seclusion on a given day but did not have service recorded in the Unit Instruction Log. This is an acceptable rate of error, particularly given the complexity of the AMS seclusion logs. In summary, once cross-referenced with AMS, the Unit Instruction data demonstrated that the facility is in compliance with its obligations

	around providing education services to youth who are in seclusion. However, it is worth noting that several youth spent an extraordinary amount of time in seclusion (a commentary on the facility's disciplinary practices, not on the education program). For example, youth CC spent 16 days in a row in seclusion with only one day out in the general population. Another youth, TB, spent 8 days in a row in seclusion. The facility's reliance on seclusion to address violent misconduct is discussed in provision III.A.3, above. Revisions to the sanctioning grid, to be implemented in the very near future, should decrease the amount of time youth spend in seclusion, and by extension, the need for Unit Instruction. Unit Instruction is an essential tool to ensure that education services are not disrupted by the disciplinary system chosen by the facility.
Recommendations	The facility is in substantial compliance with this provision.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.1, prepared at my request • Education staffing roster, October 2012 through March 2013 • Unit Instruction data, February and March 2013, and follow-up discussions with Scioto and DYS school administrators via email. • AMS Seclusion Records, February and March 2013 • Attendance records, by unit, October 2012 through March 2013

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 19 special education students in custody as of April 19, 2013 (approximately 41% of the total population; 59% of the females and 31% of the males). Of these youth, three student's IEPs were expired, but staff had taken steps to collect the necessary information and schedule IEP meetings during the month of April 2013. The other 16 youth had current IEPs and current eligibility. The State has implemented a solid, multi-level process to ensure the quality of the IEPs written at Scioto. For teachers, a variety of tools have been created: • *IEP Documentation Guidelines Checklist*: discusses the procedures for submitting draft IEPs for review, what needs to be completed during the IEP meeting, and what documents need to be submitted once the IEP meeting has been held. • *IEP Goal Planning Worksheet:* requires teachers to articulate the various components of a well-written IEP goal and to devise a plan for how progress will be measured. • *Goal Tracking Sheet*: for each IEP goal, asks whether the goal was met or not met, and whether a problem with how the goal was articulated made it difficult to measure. [Recommendation: it might also be useful to ask the teacher to indicate the basis for determining whether the goal was met or not, although the review of Progress Reports may address quality assurance needs in this area.] The Special Education Administrator at the facility also reviews IEPs each month. The following documents are used to guide this review: • *Continuous IEP Compliance Monitoring Checklist*: assesses, in detail, whether the required content is present within each of the 14 sections of the IEP document. Written feedback is provided to the teachers in order to improve their skills.

	• *On-Site Monthly Monitoring Form*: used to rate a sample of 10 IEPs on 12 performance measures (e.g., whether the IEP is current, whether the ETR is current, whether the goals and objectives are appropriate, whether progress notes have been updated, whether school refusals are being addressed, if parents have been properly notified, etc.). • *Monthly Local Special Education Accountability and Compliance Review*: provides summary statistics for each of the various indicators measured using the Monthly Monitoring Form. These monthly reviews are "Tier One" of the QA program. 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. Sadly, the extremely talented DYS Special Education Director retired during the current monitoring period. She has not yet been replaced and thus Tier Two was not completed during the current monitoring period. However, the excellent results obtained via the Tier One process (at least 90% compliance in January, February, and March) make this hiatus less of a concern. Tier Two should be reinstated as soon as possible to maintain the integrity of the QA system. In Tier Three, each of the DYS schools is audited annually by DYS and also tri-annually by the Ohio Department of Education. Neither of these audits was scheduled during the current monitoring period.
Steps Taken to Assess Compliance	<u>*Special Education Population and IEP Development*</u> Across the current special education population, 16 of the 19 students (84%) qualified under the Emotional Disability category, one student had a Specific Learning Disabilities (5%), one student was Cognitively Disabled (5%), and one student was Other Health Impaired (5%). With 4 special education teachers currently on staff, the caseload sizes are well below the state limits (generally, 12 for ED; 24 for SLD). The Monitor reviewed a sample of the last 10 IEPs written by Scioto staff prior to the Monitor's April 2013 site visit (53% of the current special education population). As expected after reviewing the QA results, all of the procedural requirements were met and the content of each section of the IEP conformed to the IDEA's requirements. What was particularly impressive was the level of consideration given to the constellation of services that was prescribed for each student. The student's response to the previous level of service was discussed and reconsidered to determine whether a different arrangement might better fit the student's needs. In some cases, the service was delivery was modified with the hope that the student would become more engaged in the program. For example, one student had previously received Occupational Therapy (OT) services in the general education classroom, but the therapist noted that the youth did better when she worked with him 1:1. The team modified the service delivery accordingly.

IEP Goal Development

The quality of articulation of the IEP goals and objectives is paramount to ensure that students progress through the curriculum. This task is much easier when the teacher/team can relay 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 student's behavior and school attendance.

Similarly, the Present Level of Performance section used to set up each IEP goal includes relevant test scores and descriptions of the students' strengths and weaknesses in the subject matter at hand. This information provided necessary context for the goals and the underlying objectives. Nearly all of the goals reviewed across the 10 IEPs were individualized, measurable and appeared to be achievable within a 1-year period, and the objectives identified the skills necessary to meet the goal. Behavior goals were 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. These goals and objectives provide a solid platform from which student progress can be measured.

Progress Reporting

Meaningful progress reporting is essential to ensuring compliance with IDEA. 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 the 15 special education students (100%) who were at Scioto at the end of the Jan-March 2013 grading period (the other four were admitted just before the grading period ended, or their IEPs had just been developed). As noted in the previous Monitor's Report, DYS has a dependable procedure for ensuring that progress reports are issued each grading period. Further, the content of the progress reports continues to provide tangible, meaningful assessments of the extent to which students have acquired the skills needed to progress through the curriculum.

Most of the 15 progress reports offered detailed, comprehensive descriptions of students' progress on behavior, academic and transition goals. Most flowed logically from the goal, to the assessment information, to a conclusion about the extent to which the student was

	progressing. The best of the reports offered both specific assessments (e.g., "In a 108 word essay, there were 10 capitalization errors and half a dozen punctuation errors…") and general conclusions about the student's progress (e.g., "While he can express his thoughts fairly clearly in writing, it is full of errors and lacks proper structure."). Occasionally, specific objectives were listed (e.g., remain in the designated area, complete assignments, respect personal space), but only a general indicator of progress was given (e.g., "the youth received 8 YBIRs."). While this may be a good starting place, the assessment of progress would be more precise if the teacher discussed the nature of those 8 YBIRs and their relationship to the objectives. Similarly, a couple of reports contained reasonable goals (e.g., "Explore job opportunities") but contained assessments that were non-responsive (e.g., "student is passing all classes…studying for the GED…had 8 unexcused absences"). These examples refer to a very small minority of IEP Progress Reports—most of those reviewed gave sufficient information about the youth's classroom performance. Together, the IEPs, goals and objectives and progress reports document the planning and delivery of special education services that are responsive to individual student's needs. Most importantly, the progress reports reveal that most of Scioto's students are making progress toward their behavior, academic and transition goals via the services they receive in the special education program.
Recommendations	The State remains in 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, January through March 2013 • Review of the n=10 IEPs development most recently at Scioto (53% of the current special education population) • Review 15 Progress Reports from the January-March 2013 grading period

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	Although vocational eligibility criteria normally require students to be either Juniors or Seniors (by credit), Scioto obtained a waiver from the ODE to serve a larger segment of its student population. Many of Scioto's 9th and 10th graders are between 17 and 19 years old, are behind in credits and may not graduate. They would benefit greatly from opportunities to develop vocational skills and thus the ODE granted the facility the flexibility to allow such youth to participate in the programming. In its self-assessment, the State discussed data on student enrollment in the three currently available vocational classes. As of April 22, 2013, there were 47 youth on the school roster. Ten of these were graduates, and ten were housed on the PROGRESS Unit, leaving 27 students in the general population. Of these: • 7 students (26%) 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); • 5 students (19%) were enrolled in Career-Based Intervention (i.e., work-based learning, student earns credit); and • 7 students (26%) were enrolled in Transition Skills (students must take this course prior to release; includes job skills, resume building, interview skills). Overall, 71% of the students in the general population were involved in vocational courses, along with one or two graduates who were simply interested in the course offerings. Even with the expansion of the "eligibility criteria," each of the three courses has sufficient capacity to serve significantly more students if needed. The Ohio DYS vocational programs were audited twice during the previous 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	The State has continued its efforts to increase the proportion of youth who are engaged in vocational programming. All students in the general population 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. Some of Scioto's students simply are not eligible (because they are too young and are on track to graduate). Further, a significant portion of Scioto's students is housed on the PROGRESS Unit (i.e., 21% of the students included in this review). These students do not have access to the AOT classroom and are not permitted to have jobs (CBI). However, once they are transferred to the Transition Unit, where they attend school with the general population, they are enrolled in the courses they need. The State provided documentation showing such enrollments for two youth who recently transferred from the PU. All youth take the Transition Course at some point 3 to 6 months before their scheduled release date. The Monitor has expressed a preference for hands-on learning opportunities and the facility has been vigilant about identifying new opportunities. As noted in the Programming provision (III.F.1), an 11-week Barbering class offering certification will soon be available. In addition, a few of the facility's volunteers are employed in various trades (e.g., construction, landscaping) and have agreed to provide hands-on programming to students. Currently, 8 students are formulating ideas for a cabinet-making project. In summary, the opportunities for students to develop job and employability skills are far greater than they were at the time Stipulation was signed. Scioto's available 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.
Recommendations	The State remains in 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, January-March 2013 grading period • Documentation of vocational enrollment for two former PU students • ODE Office of Exceptional Children audit report, November, 2012 • ODE Office of Career-Technical Education audit report, November 2012

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

Civil Action No: 2:08-cv-475

Monitor's Fourth Report

Addendum—Mental Health Provisions

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INTRODUCTION

This report is an addendum to the draft report submitted by the Monitor on May 13, 2013. This report contains the subject matter expert's, Dr. Daphne Glindmeyer, findings regarding the status of compliance for the 20 provisions related to mental health services and documentation.

The terms of the Stipulation require the State to perform a self-assessment for each of the provisions. During the current monitoring period, the State provided an assessment of only a subset of the provisions—only those found in Non-Compliance in the previous report. The purpose of this requirement is to ensure that the State has adequate internal mechanisms to identify and respond to problems in each area. The lack of self-assessment data, and the historical difficulties in obtaining Quality Assurance data in the area of mental health services do not inspire confidence in the State's internal mechanisms for oversight and review. The Monitor and subject matter expert hope and expect that a more comprehensive self-assessment will be conducted during the next monitoring period.

EXECUTIVE SUMMARY

The facility is in substantial compliance with 4 (20%) 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 2 of the provisions (10%). 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. These policies were signed following the end of the monitoring period and are slated for full implementation by May 31, 2013.
- 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 and those in seclusion 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 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.
- Review, analyze, and interpret raw data generated in order to determine the need for performance improvement of an individual clinician, enhanced training for facility staff, or systems issues that may be impeding treatment. Trend these data over time in order to assess for improvement or the lack thereof.

The table below shows the history of compliance with each of the mental health provisions. As indicated, the compliance rating was increased for only one provision (III.G.2, from NC to PC). Compliance on the other provisions remains the same as the previous reporting period.

Table 1. Compliance Ratings for Each Provision					
No.	Provision	1st Report	2nd Report	3rd Report	4th Report
Mental Health Services					
III.B.1	Mental Health Screening	PC	PC	SC	SC
III.B.2	Immediate Referral to QMHP	PC	PC	SC	SC
III.B.3	Identification of Unidentified Youth	NC	PC	PC	SC
III.B.4	Mental Health Assessment	NC	PC	PC	PC
III.B.5	Adequate Care and Treatment	NC	PC	PC	PC
III.B.6	Treatment Planning	NC	PC	PC	PC
III.B.7	Treatment Teams	PC	PC	PC	PC
III.B.8	Integrated Treatment Plans	NC	PC	PC	PC
III.B.9	Access to QMHP	NC	PC	SC	SC

III.B.10	Involvement in Housing and Plcmt	NC	PC	PC	PC
III.B.11	Staffing	NC	PC	PC	PC
III.B.12	Medication Notice	PC	PC	PC	PC
III.B.13	Mental Health Medications	PC	PC	PC	PC
III.B.14	MH/DD Training for Line Staff	NC	NC	NC	NC
III.B.15	Staff Mental Health Training	PC	PC	PC	PC
III.B.16	Suicide Prevention	PC	PC	PC	PC
III.B.17	Transition Planning	PC	PC	PC	PC
III.B.18	Oversight of Mental Health	NC	NC	NC	NC
III.G.1	Progress Notes	PC	PC	PC	PC
III.G.2	Accessibility of Information	NC	NC	NC	PC

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	This provision was not discussed in the facility's oral self-assessment.
Steps Taken to Assess Compliance	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 and in cases where it was warranted, the Substance Abuse Staffing form. It was notable that nine of ten assessment examples provided recommended further assessment by psychology staff to complete a Behavioral Health Appraisal. In nine of ten intake packets documentation of the immediate screening by nursing staff, and results of the MAYSI-2 were included. In the previous monitoring report it was noted that the MAYSI-2 forms did not always include the date of the completion of the instrument. Per the review of the nine examples provided where these documents were included, this improved, as seven of the nine available examples included date information. 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 and other policies related to behavioral health were reportedly signed in May 2013 (after the end of the current monitoring period, March 31, 2013). It was reported that the training for new policy and procedure was progressing, with full implementation of the revised behavioral health policies scheduled for May 31, 2013. Given that ODYS has made progress with regard to completing policies and has reportedly instituted training with the plan to fully implement policies, this provision will remain in substantial compliance. 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	This provision was not discussed in the facility's oral self-assessment.
Steps Taken to Assess Compliance	This was an area of continued 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. There have been continued examples of youth who have transferred from the facility to the mental health unit at IRJCF and to the Parmadale program. 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. As discussed in other areas of this report, quality assurance systems remain lacking. Large amounts of raw, unanalyzed data were presented for review. It is necessary that the facility begin to review, analyze and interpret the data collected in order to determine the need for corrective action.
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	Substantial Compliance
Self Assessment	The facility's oral self-assessment did not include a discussion regarding this provision.
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. There are currently two full time mental health nurses. One nurse is assigned to the general population, including the units where female youth are housed. The second full time nurse is assigned to the Progress Unit and performs rounds every weekday. Also, a psychiatrist has been assigned to the Progress Unit, beginning work there during the previous monitoring period. As youth are no longer confined to their cells on the Progress Unit, this has alleviated the need for daily mini mental status reviews. This is addressed in the Progress Unit status report, and therefore will not be addressed here. A review of the youth population revealed that of a total of 54 youth housed on campus, 17 were female. Of the 17 female youth, 16 (94%) were assigned to the mental health caseload. Of the remaining 37 male youth, 25 (67%) were assigned to the mental health caseload. For the overall facility census 41 of a total of 54 (75%) youth were assigned to the mental health caseload. Additionally, via a review of the caseloads of psychology staff assigned to the Progress Units, it was apparent that 95% 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." 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 maintain 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	The facility's oral self-assessment did not include a discussion regarding this provision.
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 close of this monitoring period. It was reported that the policies were signed on or about May 10, 2013 with completion of training and full implementation scheduled for May 31, 2013. 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. Eleven 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. The summaries generally included information regarding the youth's progress at the facility. They also in some cases included the youth's diagnoses and prescribed medications. In no example were the specific justifications or diagnostic criteria for a specific diagnosis reviewed in the documentation. As discussed below in provision III.B.18, Clinical Supervision Session documents included a section entitled review of diagnostic criteria.

	The data presented in a raw, unanalyzed form. When calculated, it was determined that there were a total of 22 reviews covering the time period 1/16/13 though 3/7/13. There were a total of 71 youth records reviewed. With regard to the review of diagnostic criteria, 55 or 77% were noted as not reviewed and 22% noted as reviewed. This is an area that the facility must consider for additional staff training. As data were not compiled and reviewed by the facility, it was not possible for them to determine trends or issues other than for an individual provider. A review of the tabulations above revealed serious issues with regard to review of diagnostic criteria for a particular diagnosis. 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	The facility oral self-assessment did not include a discussion regarding this provision.
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, it was apparent that there were ongoing attempts to integrate youth specialists 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. Data regarding these reviews were not provided for review. 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 an occupational therapist (OT). Two youth were in attendance, and the OT did an excellent job of engaging the youth and working through their resistance to participate. The youth were participating in an activity where they designed a CD cover describing their life, and a playlist of songs that describe “where you are, where you have been, and where you are going.” This was an excellent modality to spark discussion among the youth and to determine their insight regarding behaviors and interactions. The second group was led by a social worker. This worker sat at a table

	with the youth and engaged them with short scenarios that were then discussed by the five group participants. The youth were engaged, reviewing scenarios and identifying feelings that were provoked by the scenarios. It should be noted that the scenarios were short, so they held the attention of the youth. These group observations were improved over observations performed for previous monitoring visits. Given these observations, it was apparent 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. As raw data regarding treatment contact hours and group therapy contacts were provided, it was not possible to determine the number of groups or frequency for all youth. When reviewing individual youth there was cause for concern. For example, Youth #777 had a total of five psychotherapy groups documented in the period of time between 1/14/13 and 4/15/13, a period of three months. If group were provided weekly, this youth should have participated in a total of 12 groups. A review of this youth's treatment plan indicated that this youth should be participating in weekly psychotherapy groups. Unfortunately, given the manner of the presentation of the data, it was not possible to determine when these groups occurred. Concerns remain with regard to appropriate diagnostic assessment, case formulation, and treatment plan development. The lack of appropriate case formulations and justification for specific diagnoses is discussed throughout this report. This is another area where systematic quality assurance monitoring would be beneficial. Review of progress notes regarding both group process and individual treatment revealed some improvements with regard to the documentation of the group focus and the youth's participation. Individual therapy notes were also improved somewhat; however, here 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). 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 regarding the treatment program on the Progress Unit were discussed in the previous monitoring report. During this visit, there were obvious improvements. This issue was reviewed in the Progress Unit status report and will not be reiterated here.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue to improve documentation of group and individual therapeutic interaction and review this documentation via a quality assurance process. 2. Analyze and interpret the raw data provided regarding mental health contacts to determine the actual amount of mental health treatment a particular youth is receiving and to determine if this meets the recommendations set out by that youth's treatment plan. 3. Ensure the provision of evidence based group therapeutic interactions. Reportedly, treatment integrity monitoring of group interactions was occurring; however, data regarding this monitoring was not provided for review. 4. 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. 5. Determine and ensure that appropriate numbers of youth are assigned to specific group therapy sessions. 6. Continue the integration of treatment provider disciplines in order to achieve an interdisciplinary model. 7. Continue to engage and encourage direct care staff to participate in group modalities and in the overall treatment program for the youth. 8. 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. 9. Review the Progress program, and ensure that youth are receiving appropriate mental health treatment via this program. 10. 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	The facility's self-assessment was delivered orally following the monitoring visit. This provision was not discussed.
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. Implement newly signed policy and procedure regarding behavioral health services. The complete implementation is scheduled for May 31, 2013. 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's self-assessment was delivered orally following the monitoring visit. This provision was not discussed.
Steps Taken to Assess Compliance	Three treatment team meetings were observed during this monitoring visit. Two team meetings were observed on the Progress Unit, one meeting was observed in general population. In no instance were the youth's parent or guardian present in person or via telephone. In both meetings observed on the Progress Units, the treating psychiatrist was in attendance. The psychiatric nurse was present for the treatment team meeting observed in general population. In the intervening period since the previous monitoring report, there has been much discussion regarding the necessity for the youth's treating psychiatrist to participate in IDT. Currently, ODYS has created a system whereby psychiatry participates in treatment team as they or the team deem necessary. ODYS has created a process by which this consultation should occur. Per interviews with the facility psychiatrist responsible for treatment of the youth housed in general population, he was not attending IDT. He indicated that mental health staff were free to come to speak with him regarding a particular youth. He discussed one psychologist in particular who scheduled time to meet on a weekly basis. He indicated that he found this consultation productive. Data regarding psychiatry consultation to the IDT were not provided for review.

	In all three IDT meetings reviewed, the IDT reviewed the youth's recent behavioral challenges. Youth Specialists were noted to actively contribute to the IDT discussion. Unfortunately, in one IDT meeting observed, while the Youth Specialist had good insight and made excellent suggestions to the team, the team discounted his opinion, interrupted him while he was speaking twice, and did not attempt to fully engage him in the discussion. This was unfortunate. 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. A review of the IDT minutes for the three months prior to the monitoring visit revealed improvements with regard to descriptive detail of the meeting. This was especially evident in IDT minutes generated via the Progress Units. This topic is discussed in the status report, and thus will not be reiterated here.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review the frequency of psychiatric consultation to IDT for youth on general population. 2. Maintain the involvement of the psychiatrist in IDT for youth on the Progress Units. 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. 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. 6. 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 meetings • 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	The facility's oral self-assessment did not include information regarding this provision.
Steps Taken to Assess Compliance	Document review revealed improvements in ITP documentation. Specifically, youth strengths and measurable goals were identified. 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. Inclusion of the youth's psychotropic medication as an intervention with an objective outlining the need for medication compliance was located in some examples, which was an improvement. Out of a total of ten ITP available for review, five were regarding youth prescribed psychotropic medication. Of these, two had mention of psychotropic medication in their ITP documents. One noted challenge were the number of treatment goals included in the ITP. For example, Youth #444 had a total of five treatment goals with four of those noted as active. Included in these goals were a total of 12 objectives. This was overwhelming, and would likely be difficult for both the youth and the treatment team. Choosing a few goals (three or less) and focusing on these may be more workable. ITP documents for the Progress Units were addressed in the status report, and therefore will not be reiterated here. 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 was recently signed, with full implementation planned by May 31, 2013. 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 committing ongoing attention to the improvement of 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. Complete the implementation of 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 inclusive of medications 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). Provide the analyzed results of this quality assurance monitoring for review.
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's self-assessment was provided orally. No information regarding this provision was included.
Steps Taken to Assess Compliance	In the previous monitoring period, it was noted via a 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, 65 examples of youth contact with psychology staff were provided. Data regarding the time of the youth's initial request was only available for 18 of these contacts. When reviewing these, the average time between the youth's request for services and receipt of services was 2 hours and 45 minutes. There was a range of immediate (0) to 20 hours. In five examples, youth were seen immediately. Per the monitoring visit and observation on the units, 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 monitoring tours was access to mental health services for youth housed on the Progress unit. These youth were previously assigned to single cells where they remained the majority of the day. Currently, youth are spending the majority of their day on the unit, out of their cells, with youth on phase one in ambulatory restraints ("gators") when they are

	outside of their cells. Given the youth's improved access to staff, there is no longer a need for daily mental status checks. There are concerns with these youth spending increased time daily in restraints and the negative effects that this could have on both their mental health treatment and mental health symptomatology. This issue; however, is reviewed in the Progress Unit status report and thus will not be reiterated here. 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. In previous monitoring visits, youth on the Progress Units had expressed dissatisfaction with the frequency of contact with their mental health providers. This was improved over previous visits. 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. 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. 2. 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. No information regarding this provision was included.
Steps Taken to Assess Compliance	During the monitoring visit, it was discussed that policy and procedure had been signed with training and implementation planned for May 31, 2013. With regard to placement on the Progress Units, the census on these units had decreased from the previous monitoring visit. Previously, there were 21 youth housed on the Progress units. This monitoring visit, there were a total of 10 youth (Phase I housed four youth and Phase II housed six 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. This process was reviewed in the status report for the Progress Units and thus will not be repeated here. It should be note that overall, these assessments had improved and were more comprehensive. Ten examples of intake assessment and subsequent Behavioral Health Appraisal documents were reviewed. In the sample provided, nine youth were referred for a Behavioral Health Appraisal at intake. Included in the Behavioral Health Appraisal was a recommendation for placement. Three of the examples received were recommended for placement in the general population. Two of the examples included a referral to general population with consideration for transfer to the Parmadale program. While overall there were improvements noted in the quality of documentation, all documents were lacking with regard to the review of specific diagnostic criteria reviewed in order to make a diagnosis. This is an area that should be monitored via quality improvement. 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 the implementation of newly signed behavioral health policies. 2. 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. 3. Begin quality assurance monitoring regarding intake and placement documentation and processes. 4. Indicate the method by which youth who are not referred for a Behavioral Health Appraisal are assessed for appropriate placement within the facility. 5. Improve documentation promulgated by the Behavioral Health Appraisal specifically with regard to the justification of a specific diagnosis.
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's self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	A review of the provided documents revealed a spreadsheet of all behavioral health positions. There were a total of nine filled social work positions (including two supervisory positions). This number was reduced from the prior monitoring period, where there were a total of 14 social work positions. Of the current nine filled positions, six were licensed. There were a total of seven filled psychology positions (including one supervisor). This was reduced from the previous monitoring period where there were a total of eight psychology positions. Of the current seven positions, three were psychology assistants (unlicensed). Four were licensed psychology staff (inclusive of the psychology supervisor). There were two licensed psychiatric nurses. Other mental health staff positions included one occupational therapist, a transcription service, and the two facility psychiatrists. Schedules for psychology staff were provided for review. Per conversations with facility staff, 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. New policy and procedure slated for full implementation May 31, 2013 will reportedly create a behavioral health team in contrast to the previous silos inherent in having artificial divisions between the departments of social work and psychology. In the intervening period since the previous monitoring report, vacant positions had been cut, and the facility now was fully staffed. There had also been a reduction in the facility youth population, allowing for more reasonable caseloads. Should the population expand, it may be advantageous to examine the current behavioral health staffing pattern

	and required 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. 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 the previous 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. It should be noted that in the intervening period, the youth population had dramatically decreased at the facility, allowing the nurses extra time to attend staffing and perform nursing education with the youth. 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 1/14/13 and 4/15/13 there were 2,843 total contacts with female youth. This included group, individual, and crisis intervention. Unfortunately, these contacts were not limited to mental health contacts, so it was not possible to determine the average amount of mental health services received per youth. • Between 1/14/13 and 4/15/13 there were a total of 6,203 contacts with male youth. This included group, individual, crisis intervention, and daily door checks on Progress Units. Unfortunately, these contacts were not limited to mental health

	contacts, so it was not possible to determine the average amount of mental health services received per youth. While these mental health units are an improvement from prior contact reports, there remain issues. For example, given the raw data presentation, it was not feasible to review each individual youth's data in order to determine the amount of actual mental health treatment or mental health contact he or she had received. It is necessary that the facility begin to review, analyze, and interpret data in order to determine this. Given the above information, there were a total of 8,686 contacts over a three-month period. This was increased from 3,998 noted in the previous monitoring report. 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 non-treatment related activities which artificially inflate this number. 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.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Determine the need for additional staff via workload indicators 2. Improve coordination between staff disciplines via the development of the behavioral health department. 3. Ensure coverage for staff during required trainings and other absences. 4. Ensure the creation of a unified behavioral health team. 5. Begin quality assurance to review both the quantity and quality of individual and group therapeutic interactions provided to youth. Provide analyzed and interpreted data to the monitor for review.
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 did not include information regarding this provision.
Steps Taken to Assess Compliance	Draft policies and procedures had been approved and signed. The facility was in the process of "training the trainers" and had plans to complete staff training regarding the revised behavioral health policies with full implementation of said policies planned for May 31, 2013. Fourteen 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) is 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 12 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. It was confusing as the parental consent information was located on the second page of the consent document, and in all cases, this document did not include the youth's name. In certain situations, it was a challenge to match the youth's consent form with the parent consent form. Adding the youth's name to the second page of the form may be helpful. 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. Documentation of quality improvement monitoring (via physician peer review or other modalities) was not provided for this monitoring period. 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 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. During record review, examples of quizzes that nursing staff had developed to assist in youth education regarding prescribed medications were located. These multiple-choice instruments allowed the youth to objectively indicate their understanding of medications. 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. Consider adding the youth's name to the second page of the physician's consent form. 3. Implement policy and procedure regarding informed consent in conjunction with other behavioral health policy. 4. Continue the peer review or begin a quality assurance process for informed consent and other psychiatric documentation. Provide this information to the monitor for review. 5. Ensure that medication information sheets currently available at the facility are provided to the youth and sent via mail to their parent or guardian. 6. 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's self-assessment was provided orally. Information regarding this provision was not included in the discussion.
Steps Taken to Assess Compliance	There are currently two psychiatrists providing services at the facility. One physician provides services targeted to the general population, the other to youth housed on the Progress Units. During this monitoring visit, both psychiatrists were interviewed, and clinic with one psychiatrist was observed. With regard to the second psychiatrist, the monitor has had the opportunity to observe his clinic several times during monitoring at another ODYS facility. 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 per 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 has provided coverage and expanded resources. In addition, the ODYS administrative psychiatrist has indicated willingness to provided clinical services as the need arises. The psychiatrist assigned to the Progress Units 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. The ODYS administrative psychiatrist is a board certified child and adolescent psychiatrist, and it was noted that he has provided clinical consultation as necessary. Psychiatric documentation was received for ten youth. There was

	documentation with regard to psychiatric evaluation; ongoing medication management; and laboratory results. Physician documentation included specific requirements for monitoring. For example, in the record of Youth #222, there was documentation that the physician reviewed this youth's vital signs and body mass index. It was also noted, "he is now due for his quarterly labs…does not like his blood drawn…explained to him again the importance of this frequency of blood work especially considering that he is on Abilify…reminded him of the potential metabolic consequences…I ordered the hemoglobin A1C and basic metabolic profile." The above is contrasted with the record of Youth #333, in which a youth was prescribed Abilify. This youth was transferred to Parmadale in October 2012, and then returned to this facility prescribed Risperdal. The physician's note authored on her return indicated that the physician did not have access to records from Parmadale, and the medication regimen had been altered. There was no notation of laboratory examinations reviewed or requested. Further review of the available records revealed similar disparities between providers. Medication compliance data was readily available and reportedly provided to the psychiatrist during clinic. Given the presence of the Administrative Psychiatrist, psychiatric peer review had begun, but not data regarding reviews performed during this monitoring period were provided. In an effort to standardize medication management/laboratory monitoring of specific psychotropic medications, the administrative psychiatrist had revised a laboratory matrix, which designated required laboratory examinations for youth prescribed particular psychotropic medications. This revision was pending the monitors review and comment. Once 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, 32 youth were prescribed medication by the psychiatrist. This was a similar result to the previous monitoring period where 63 youth were prescribed psychotropic medication. This was an approximately 50% reduction in youth prescribed medication. This was also a function of the vastly reduced population at the facility, as there are currently a total of 54 youth at SJCF. 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 if not more frequently. Over time, 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. Given the current low census, it would appear that psychiatric resources are sufficient, but this should be objectively determined. 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. Revised behavioral health

	policy and procedure was recently signed, with training and full implementation scheduled for May 31, 2013. This may clarify some of the issues outlined in this discussion.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Complete the training and implementation of new behavioral health policy and procedure including policy regarding psychotropic medication management. 2. 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. 3. 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). 4. Ensure clinical coverage for the current psychiatric treatment provider. 5. Maintain the document regarding the current mental health caseload. Edits to this document may assist in quality assurance. 6. Continue 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. Provide these documents to the monitor for review. 7. Ensure that youth are receiving proper laboratory examinations and side effect monitoring commensurate with the psychotropic medication they are prescribed. This would require implementation of the matrix (which is pending the review of the monitor) and quality assurance monitoring. 8. 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. It was discussed that direct care staff, specifically staff assigned to the Progress Units receive a large amount of informal training. It was also discussed that there is a training planned for September 2012 regarding responses to trauma. It was reported that with regard to in-service training, 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 reports, 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 monitoring report authored in May 2012, 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 "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 the initial two-day training. Evaluations completed by the participants revealed that 72.22% of the ratings were "excellent." Per staff interviews, this training was repeated in May 2013. At that time, it was reported that 12 youth specialists attended. As such, a total of 20 youth specialists have participated (14% of a total of 140 facility youth specialists). Given the large number of staff requiring specialized training regarding specific mental health and developmental disabilities, this provision will remain in noncompliance. During the facility self-assessment ODYS indicated that there were additional data regarding this provision, and that this would be forwarded to the monitor for inclusion in the report. This had not been received at the time this report was authored. As outlined in previous reports, pre-service training for new employees includes the following topics: • 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 No information regarding edits to this curriculum was received. 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's self-assessment was provided orally, and did not include information regarding this provision.
Steps Taken to Assess Compliance	Per the document request, copies of any newly developed mental health training curricula were requested and the response indicated no newly developed mental health training programs. During the previous monitoring period, and discussed in the previous report, there was documentation of mental health training presented by Lisa Boesky, Ph.D. provided to the monitor. It was reported that there were plans to repeat this training in May 2013. As of the time this report was authored, no additional documentation regarding a repeat of this training had had been received. Documentation of training provided in the twelve months prior to the monitoring visit was requested. This documentation was difficult to review, as in many instances; the aggregate data were not included. For example, with regard to active new employees 2013, there were a total of 11 youth specialists identified. A variety of topics including Mental Health were noted; however the data did not include information regarding staff completion of training. For active veteran employees, it was noted that with regard to the "MYR" provided to direct care staff (which reportedly includes topics regarding mental health) no staff had completed the training in either the first or second quarter. For the first quarter, 285 staff required "make ups" and for the second quarter, 285 staff required "make ups." No other mental health topics were included in the spreadsheet. With regard to behavioral health training, there were numerous topics outlined. Specific mental health training provided by the facility included VERA family engagement, Child Abuse & Neglect, MYR, Verbal Strategies." Of the training dates documented, the vast majority were in early 2012. There were no amalgamated data reports provided indicating the percentage of behavioral health staff completing required training. 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 facility should analyze and review training completion data to ensure that staff are completing required training in a timely manner. This was not evident based upon the raw data received.
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's self-assessment was provided orally and did not include information regarding this provision.
Steps Taken to Assess Compliance	In the previous monitoring period it was 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 at the time of the monitoring visit. It was noted that behavioral health policies and procedures were in the early phase of implementation with plans for full implementation by May 31, 2013. The following information was provided for the previous monitoring review, and will be included here for comparison when the revised policy is fully implemented. *"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 the process by which ODYS would collect data. No specific data regarding this quality assurance requirement were presented for review. In the previous three months, there were a total of sixteen 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. Implement revised 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's 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 four examples of psychological services summaries completed by the youth's current treatment provider in preparation for release and/or transfer. In general, these documents were far improved over prior documents reviewed. It was noted that one weakness in the format was the difficulty in determining the youth's discharge diagnoses. There was not a specific section in the form to document that information. In addition, the examples were lacking with regard to a discussion of the constellation of symptoms that led the behavioral health providers to make a particular diagnosis. Otherwise, there was an appropriate review of the youth's course of treatment in the facility as well as a listing of the youth's discharge medications. In three of four examples a definitive location for follow up was identified. In the fourth, it was noted that the "youth is likely to require follow up." While recommendations for different treatment modalities were documented, there was no specific location indicated for the youth to contact in order to access treatment. 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. Ten 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. In six examples, the youth were prescribed psychotropic medications. In five of these examples, it was documented that a thirty-day supply of the medication(s) was provided to the youth. Specific referrals (e.g. clinic name, phone number) were not included on this document. Per ODYS staff, policy and procedure revision had been completed, policies were recently signed, and training of staff had begun with plans to fully implement new behavioral health policy and procedure as of May 31, 2013. 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. Implement Behavioral Health Policy and Procedure that reflects he 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 and documentation thereof.
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's self-assessment was provided orally, and revealed that ODYS opined that a quality assurance monitoring system is in place. ODYS has reportedly continued to review the CaseNote database to ensure that youth are receiving treatment at the required frequency to ensure compliance with the individualized treatment plan. It was reported that staff are now beginning to review the content of progress notes in order to ensure that the notes reflect quality treatment. It should be noted that via a parallel agreement, there are plans to create an improved quality assurance system for mental health and psychiatry.
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 have been signed, and ODYS has completed a "train the trainers" session, with plans to complete all training and fully implement the new behavioral health policies as of May 10, 2013. Quality assurance documents were requested. In response to a request for all quality assurance data regarding suicide precautions, a description of how monitoring is performed was provided. No data (either raw or analyzed/interpreted) were provided. In response to a request for any mental health quality assurance documentation, only quality assurance audits regarding psychology staff were provided for review. It has been reported that quality assurance via treatment integrity for group therapy is being performed; however, data regarding this were not provided. In

	addition, it has been reported that quality assurance monitoring regarding treatment teams is being performed; however, data regarding these efforts were not provided. With regard to the Clinical Supervision Session documents provided the forms included sections headed “caseload review”, “quality review”, and “professional review.” There was no review of the data, rather, they were presented in raw form. In an effort to perform a review, these data were tabulated by the monitor as follows: There were a total of 22 reviews provided covering the time period 1/16/13 though 3/7/13. There were a total of 71 youth records reviewed. With regard to ITP’s, 46 or 65% were complete, and 25 or 35% were incomplete. It should be noted that the reason that the ITP was incomplete was not included in the raw data. With regard to updated progress notes, 100% were noted as updated. With regard to the review of diagnostic criteria, 55 or 77% were noted as not reviewed and 22% noted as reviewed. This is an area that the facility must consider for additional staff training. As data were not compiled and reviewed by the facility, it was not possible for them to determine trends or issues other than for an individual provider. A review of the tabulations above revealed serious issues with regard to review of diagnostic criteria for a particular diagnosis. 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 outside of periodic peer review. Data regarding peer review were not provided for this monitoring period. 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). It should be noted that the provision of raw, unanalyzed data does not constitute quality assurance. It is imperative that the facility collect, analyze, and interpret data in such a manner to ensure that they are able to both identify and address issues.

Recommendations	In order to reach substantial compliance with this provision, the State must: 1. 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's 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, the review and revision of policy and procedure had been completed, with new policies awaiting signatures, training and implementation. This process was slated for completion in the two months following the visit. 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, overall, the case conceptualizations were in need of improvement. For example, the case conceptualization regarding Youth #111 appropriately described this youth's home environment and history of mental health treatment. It was noted that this youth had a history of multiple diagnoses including: Bipolar II Disorder, not otherwise specified; Cannabis Abuse; Conduct Disorder; ADHD; Mood Disorder; ODD; Major Depressive Disorder; Depressive Disorder, not otherwise specified; and Borderline Personality Disorder. The case conceptualization did not address the veracity of these diagnoses, nor did it review specific symptoms that this youth was experiencing or behaviors that this youth was exhibiting outside of a notation that the youth "denied any current suicidal ideation, self injurious behaviors, or homicidal ideations." This document provided diagnostic impressions including: Conduct Disorder; Mood Disorder, not otherwise specified; ADHD, and Parent Child Relational Issues. Nowhere in the summary were the specific diagnostic indicators noted. Specific information regarding the presence or absence of symptoms indicative of a bipolar process (reportedly diagnosed previously) would have been expected. In addition, this youth had been previously diagnosed with borderline personality disorder, despite her age of 16 years (this diagnosis is generally not made until the individual is 18 years of age). It would be expected that this diagnosis would be discussed and discounted or that specific traits the youth exhibited

	suspicious for this diagnosis would be reviewed such that treatment planning to address these maladaptive coping mechanisms could be considered. 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 the justification of mental health and substance abuse diagnoses. There was 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 ongoing quality assurance monitoring. Statistics or quality assurance regarding response to requests for mental health services for the 90 days prior to the monitoring visit were requested. No amalgamated data were provided; however, examples of documentation regarding crisis intervention were provided. The majority of these noted the date of the contact and the length of the contact; however, it was not possible to determine when the contact was requested or when the documentation was completed. It would be appropriate to monitor the time lapse between the crisis intervention and documentation in order to ensure that providers could review documentation generated for a youth on their caseload. One provider did include timelines. This provider noted a total of 23 crisis contacts over the time period between 2.27.13 and 4.10.13. Of these, in 18 situations, the request and response time was provided. Data regarding documentation were not available. There was an average of 2 hours and 45 minutes between the time of the request for services and the response. These data were skewed by one event, where the lapse time was 20 hours. There were five events where there was no lapse time. A review of 65 crisis response documentations revealed that in nine instances, the provider indicated plans to discuss the crisis intervention with the youth's primary provider. Unfortunately, given the presentation of the raw data, it was not possible to determine if in the other cases the youth were requesting crisis services from their primary therapist, or if on call services were being rendered. In general, the documentation appeared to be thorough, providing appropriate information regarding the crisis, intervention, response, and planned follow up.
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. Implement final mental health policy and procedure. 4. Quality assurance regarding crisis intervention response, documentation, and communication with the youth's primary therapist.
Sources of Information	• Mental health records • Review of provided documents • 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	Partial Compliance
Self Assessment	The facility self-assessment was provided orally. ODYS indicated that this provision should be in Substantial Compliance. While ODYS agreed that access to information could be cumbersome, it is accessible. They were in agreement with the need for a more efficient system. In order to improve the current system, there is a training planned regarding an integration of the three databases (OIMS, SOLAR, and JJCMS). This will reportedly be in place by July 1, 2013.
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 improvement in the quality of documentation regarding mental health treatment. This is an area that would be amenable to ongoing quality assurance (with associated corrective action) and peer review. Given the facility plans to integrate three databases, with training and implementation planned for July 2013, this provision is in partial compliance.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that all mental health staff 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 for the various mental

	heath provider disciplines along with corrective action plans as needed. 3. Complete the integration project and staff training planned for July 2013. 4. Provide the monitor with the training curriculum for the database intervention, as well as documentation of staff attendance.
Sources of Information	• Mental health records • Interviews with ODYS and facility mental health staff • Medical records