IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
v.	)	CIVIL ACTION NO:
	)	2:08-CV-475-ALM
THE STATE OF OHIO, et al.,	)	
	)	
Defendants.	)	
	)	

ADDENDUM TO SECOND COMPLIANCE REPORT

Pursuant to provision V.H. of the Consent Order in U.S. v. Ohio, 2:08-CV-475, the United States, as Monitor, submits its addendum to its second report of its assessment of the State of Ohio's ("State") compliance with the June 4, 2008 Consent Order. For each mental health provision, a recitation of the provision is provided, followed by a narrative describing the United States' analysis of the State's compliance efforts, and a compliance rating. Where possible, the United States provides recommendations to assist the State attain substantial compliance with a particular provision.

On February 8, 2011, the United States submitted to this Court its Second Compliance Report. It noted in the introduction that the addendum would follow. (See Dkt. # 72 at 1). This Addendum to the Second Compliance Report represents the United States' assessment of the State's compliance with provisions B.1-18, which relate to Ohio Department of Youth Services ("ODYS") policies, procedures, and practices governing the mental health services for youth at Scioto Juvenile Correctional Facility ("Scioto"). The Addendum is organized in this order and follows the structure of the Consent Order.

The United States' assessment is based upon document review (including, but not limited to, policies, procedures, training documents, youth records, and the

State's self-assessment), the expert report from Dr. Daphne Glindmeyer, youth and staff interviews, and an on-site compliance tour in November 2010. We have attached to this Addendum the expert report of Dr. Glindmeyer. [1] The United States intends to provide a third compliance report regarding the status of the State's compliance with all provisions following its upcoming compliance tour on February 22-24, 2011. Consistent with the U.S. v Ohio Consent Order, the United States provided the State a draft version of this Addendum to the Second Compliance Report and the expert report two weeks prior to filing with the Court.

EXECUTIVE SUMMARY OF MENTAL HEALTH COMPLIANCE RATINGS

The State is in partial compliance with 16.66% of the mental health provisions (3 of the 18 provisions), is in beginning compliance with 66.67% (12 of the 18) and is in non-compliance with 16.67% (3 of the 18) of the provisions. The State has not achieved substantial compliance with any provision. [2]

Achieving "substantial compliance" with some of the mental health provisions in the Consent Order will require significant effort and resources going forward. In particular, the State will need to focus its efforts on the five provisions rated as non-compliant. In this regard, we remain committed to working with the State through technical assistance.

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[1] Dr. Glindmeyer prepared her First Mental Health Report ("Glindmeyer First Mental Health Report") labeled as Attachment E.

[2] "Substantial Compliance" indicates that the State has met or achieved all of the components of a particular provision. "Partial compliance" indicates that the State has made notable progress in achieving compliance with the key components of the provision, but substantial work remains. "Beginning compliance" means that the State has made notable progress in achieving compliance with a few, but less than half, of the key components of the provision. "Non compliance" means that State has made no notable progress in achieving compliance on any of the key components of the provision.

BACKGROUND TO MENTAL HEALTH SERVICES AT SCIOTO

In our May 9, 2007 Findings Letter, the United States addressed the mental health care services provided at Scioto. In short, the United States found that the "mental health care at Scioto's intake facility and girls' facility is constitutionally inadequate." See United States' May 9, 2007 Findings Letter at 10.[3] Specifically, the United States found that the mental health intake assessments suffered from poor data gathering and recording and often failed to address important considerations such as cognition problems, impact of trauma, school history, past treatment experiences, past treatment responses, and dysphoric moods. Id. at 11. The United States found Scioto's psychological assessments to be inadequate because they rarely included specific treatment recommendations or considered multiple concurrent conditions, despite the prevalence of such conditions among Scioto's population at the time. Id. at 12. The psychological assessments also failed to consider alternative diagnostic hypotheses and did not link the diagnoses to likely functional problems, such as socialization problems or aggressiveness. The United States found that a number of obvious candidates for psychiatric care were not referred for psychiatric assessments. Id. We found that Scioto's overall mental health staffing was inadequate, allowing for only superficial assessments without any routine follow up. Id. Consequently, youth's mental health needs were often untreated or inappropriately treated, resulting, among other things, in no treatment, counterproductive treatment, exposure to inappropriate or unnecessary medications posing serious physical or other side effects, longer periods of confinement, and needlessly greater potential for recidivism. Id. Further, based on a review of randomly selected files, the United States found that Scioto's process for identifying youth with mental illness was inadequate and that girls with significant mental disorders often went unidentified and untreated. Id. at 13. For those youth with identified mental disorders, the United States found that they did not receive "regular, scheduled treatment sessions, allowing these disorders to go neglected."

[3] The May 9, 2007 Findings Letter is labeled as Attachment F.

Id. This is not an exhaustive list of our 2007 findings, but is intended to present to the Court the bases for the requirements of the mental health provisions of the U.S. v Ohio Consent Order.

Since the Consent Order became effective in June 2008, the State has had over two and half years to improve its mental health program. Unfortunately, the State is not yet in substantial compliance with any of the 18 mental health provisions. Moreover, the State provided a self-assessment for these 18 provisions in which it claims to have already reached substantial compliance with some provisions as early as 2004—four years prior to the date of the U.S. v Ohio Consent Order and the agreement in the related case S.H. v Stickrath. We strongly recommend that the State commit to improving its mental health services with as much vigor as it did with regard to protection from harm and educational services. Based on our communications with the State in December 2010, it appears that the State recognizes that it has not made as significant progress in mental health as compared to protection from harm and that the State is eager to improve. We are encouraged that the State aspires to improve. We look forward to learning what progress the State believes that it has made since our November 2010 tour.

GLOBAL RECOMMENDATIONS

As discussed further below, we recommend that the State consider incorporating a quality assurance monitoring mechanism ("QA") as it revamps its mental health policies, procedures, and practices. As described by Dr. Glindmeyer in her report, there are various respects in which a QA mechanism would be helpful to the State. (See, e.g. Glindmeyer First Mental Health Report at 3). We also recommend that the State seek assistance as it overhauls much of its mental health services program. In September 2010, the State requested that the United States, through Dr. Glindmeyer, provide technical assistance regarding the State's draft behavioral health policies. We were pleased to do so and are open to providing similar technical assistance in the future.

COMPLIANCE ASSESSMENTS AND RATINGS

I. MENTAL HEALTH

B.1 MENTAL HEALTH SCREENING

> *The State shall develop and 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.* (See Consent Order III.B.1)

In assessing this provision, we reviewed the State's self-assessment, current and draft policies and procedures, and youth records. Based on our review, it appears that the current ODYS policies and procedures meet most of the requirements of provision B.1. Due to the lack of reception risk interviews, however, we were unable to assess the State's actual screening practice. We received assessment summaries, which were of varying quality, but did not receive any reception interviews. Without the reception interviews, it is difficult to assess the quality of the overall screening. In the future, we encourage the State to ensure that all necessary documentation to assess mental health screenings is available for our review.

We understand that the State intends to implement a new policy, "Behavioral Health Assessment, Screening, Appraisal and Evaluation," which, as the name implies, will address different aspects of a youth's behavioral health assessments including screenings. The new policy includes a plan for the creation of a Behavioral Health Review Panel to assess intake data and make recommendations about future housing, programming and treatment needs. This would be a positive step, as it would begin the interdisciplinary review and treatment process at the time of admission. In addition, we understand that the State intends to finalize and implement a policy regarding quality assurance. We recommend that the State continue to develop and implement this policy.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

The State is encouraged to seek technical assistance regarding its new youth screening policies and procedures. We look forward to reviewing this provision and the State's self-assessment (both written and oral) as it relates to this provision during our next compliance tour.

B.2 IMMEDIATE REFERRAL TO A QUALIFIED MENTAL HEALTH PROFESSIONAL

> *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.* (See Consent Order III.B.2)

In assessing this provision, we reviewed the State's self-assessment, policies, procedures, youth schedules and psychology staff schedules. Based on our review, we found that the State's current policies and procedures are adequate, but we were unable to assess the State's practice. While some assessment summaries were found to be of good quality, the State did not provide documentation regarding the referral process.[4] Specifically, the State's documentation was insufficient to assess

[4] On June 29, 2010, the United States provided the State with its request for mental health documents to be produced during the November 2-5, 2010 on-site tour. The State and the United States disagree as the reason why documentation was delayed. In order to avoid any similar problems in the future, on December 15, 2010, the United States informed the State that, for its upcoming February 2011 tour, the United States would only accept documents that are available on the first day of the tour, February 22, 2011. The United States provided the State its document request on January 19, 2011 and made Drs. Dedel, Staples-Horne and Glindmeyer available to answer any questions about the document request.

the elapsed time between the request for service and the response to that request. Since the language of the provision explicitly requires that, absent extraordinary circumstances, a qualified mental health professional ("QMHP") be "available for consultation within 12 hours of such referral" such documentation is critical to the State demonstrating its compliance. We agree with Dr. Glindmeyer's suggestion that a QA mechanism regarding the length of time to provide the consultation would benefit the State. (See Glindmeyer First Mental Health Report at 3).

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

We recommend that in its next self-assessment, the State discuss and demonstrate its efforts to reach substantial compliance with provision B.2. In particular, the State should present documentation that the State meets the requirement to have QMHP available for consultation within 12 hours of a referral, absent exigent circumstances. We look forward to assessing the State's compliance with this provision in the future.

B.3 IDENTIFICATION OF PREVIOUSLY UNIDENTIFIED YOUTH WITH MENTAL DISORDERS

> *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.* (See Consent Order III.B.3)

In assessing this provision, we reviewed the State's self-assessment, policies and procedures, youth records and draft policies and procedures. Based on our review, we found that the State's self-assessment fails to address the heart of the provision. Specifically, the self-assessment discussion does not speak to identifying youth who were not previously identified as presenting mental health or behavioral

needs requiring treatment. The State's self-assessment requires monitoring youth who are in seclusion to evaluate for decompensation, which is appropriate, but does not cover all youth. We agree with Dr. Glindmeyer's interpretation that the goal of provision B.3 is to ensure that youth who may not present with "a history of mental illness and who are not identified at the time of the initial assessment . . . are monitored over the course of their incarceration for exacerbations of symptoms and referred for mental health treatment." (See Glindmeyer First Mental Health Report at 5).

It is our understanding that the State intends to implement a new policy, "Behavioral Health Assessment, Screening, Appraisal and Evaluation." Based on the draft language provided, we are concerned about the policy's overall generic tone. We recommend adding language that addresses previously unidentified youth. We note that the draft policy requires an evaluation within 24 hours of submission for an urgent referral, and within 7 days of submission for a routine referral. (See Glindmeyer First Mental Health Report at 5). Based on the State's recent mental health staffing shortages, discussed below under provision B.11, full implementation of the State's proposed 24 hour and 7 day deadlines will be difficult to meet. While there is no certainty that the State will not be able to meet the deadlines, we highlight the possibility so the State can develop any necessary safeguards or responses. We look forward to reviewing this provision during our next compliance tour.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

As noted above, we recommend that the State ensure that the new draft policy regarding screenings, evaluations, appraisals and re-evaluations capture previously unidentified youth. Accomplishing this task will enable the State to begin its progress towards substantial compliance with provision B.3.

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, risk, 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.* (See Consent Order III.B.4)

In assessing this provision, we reviewed the State's self-assessment, youth records, and ODYS policies and procedures. Based on our review, we found that the State is currently performing mental health assessments and appraisals at intake/reception. The initial assessments reviewed provided useful information, but were found to be of varying quality. We refer the State to Dr. Glindmeyer's specific comments regarding particular assessments. (See Glindmeyer First Mental Health Report at 7).

We are encouraged to see that the State already plans to establish clinical review teams to provide formal recommendations. Lastly, it is our understanding that the draft policy, "Behavioral Health Assessment, Screening, Appraisal and Evaluation," discussed above under provision B.3, is anticipated to also address the requirements of provision B.4. We look forward to reviewing the final policy and procedure as well as documentation that demonstrates their implementation.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

We agree with Dr. Glindmeyer's recommendation that QA in this area would benefit the State. (See Glindmeyer First Mental Health Report at 8). We also

recommend that the State implement its draft policy, "Behavioral Health Assessment, Screening, Appraisal and Evaluation."

B.5 ADEQUATE MENTAL HEALTH CARE ANDTREATMENT

> *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.* (See Consent Order III.B.5)

In assessing this provision, we reviewed the State's self-assessment, youth records, ODYS policies and procedures, and group schedules. Based on our review, we determined that some treatment is currently being provided at Scioto. But we noted that the group treatment for female youth outpaced that of male youth. It is our understanding that the male mental health unit began in May 2010 in Scioto and therefore the State is creating such treatment from scratch. Nevertheless, the State must meet its obligation to provide appropriate treatment to the male mental health youth at Scioto. During our next on-site tour, we look forward to observing any evidence based group interaction scheduled for youth.

In her report, Dr. Glindmeyer discusses two group therapies that she witnessed during the compliance tour and describes youth as engaged and the facilitators as prepared. (See Glindmeyer First Mental Health Report at 9-10). Dr. Glindmeyer was particularly impressed with the level of organization by the facilitators and engagement by the youth. We commend the State on the successful group therapies observed and encourage it to make more courses available to the male youth. Despite the loss of mental health staff, group therapeutic interactions have remained relatively stable from 2009 to 2010. However, we are concerned that the loss of mental health staffing is severely reducing the number of individual

therapeutic interactions, including individual counseling, received by mental health youth. [5]

In addition, we recommend that the State ensure that the documentation in youth records clearly articulate the youth's progress towards goals in that youth's treatment plan and that youth reports incorporate or discuss targeted interventions in that youth's treatment plan. Our review of documentation found that the quality of treatment plans was of varying quality.

Despite these findings, we are encouraged by the fact that the State is already making strides towards improving its treatment program. During our November 2010 on-site tour, we were informed that the State would be implementing its new treatment program, "New Freedom Phoenix" in January 2011. We look forward to assessing the New Freedom Phoenix program and any data the State can provide regarding the efficacy of the program. We also note that the State intends to expand its treatment modalities. We look forward to reviewing the new policies and procedures for the New Freedom Phoenix program. In particular, we hope to see that the policies and procedures address the requirements of provision B.5 and ensure that QMHPs provide adequate mental health, substance abuse, treatment services, and rehabilitative services.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

In addition to our recommendations above, we strongly suggest the State take steps to improve its documentation of group and individual interactions, ensure the provision of evidence-based group therapeutic interactions, and ensure

[5] Dr. Glindmeyer found that, as compared to the year before, in 2010, there was an 18% reduction in the number of individual therapeutic interactions. (See Glindmeyer First Mental Health Report at 11).

that rehabilitative and substance abuse services are also included in the new treatment program.

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.* (See Consent Order III.B.6)

In assessing this provision, we reviewed the State's self-assessment and existing and draft policies and procedures, and we interviewed staff. Based on our review, it is our understanding that the State is in the process of revising its policies and procedures regarding the interdisciplinary treatment team and how its treatment planning will be documented. At the time of our tour, the State provided information about some interdisciplinary treatment ("IDT") team meetings that were being held. As discussed further in provision B.7 below, it appears that no psychiatrist attended the IDT meetings. This is problematic. Also, while the State is currently developing and revising its integrated treatment plan model, it is not yet complete. It is troubling that, after more than two and half years, the State has not made tangible progress in this fundamental area. The State is currently non-compliant with this provision.

Compliance Rating: Non-Compliance

Recommendation(s) to reach substantial compliance:

The State is encouraged to seek technical assistance with this provision to accelerate its compliance efforts.

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 Managers, 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 the facility 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.* (See Consent Order III.B.7)

In assessing this provision, we reviewed the State's self-assessment, Interdisciplinary Team minutes, and youth records, and we interviewed staff and observed an IDT team meeting. Based on our review, it appears that the State's draft policies do not meet all of the requirements of provision B.7. The provision lists the individuals that must be the "stable core of members" of the treatment team, such as the youth, one of the youth's teachers, and the unit manager. We found that inclusion of a direct care worker and a social worker was left to the

discretion of the treatment team leader. In addition, it did not appear that the State's policy considers situations where parental involvement would be inappropriate. The language in provision B.7 states that proactive efforts should be made to involve the parent or guardian "unless their participation would be inappropriate for some reason (e.g. the child has been removed from the parent's custody)." We recommend the State ensure that parents will not be involved in the youth's treatment meeting if inappropriate. Additionally, it was unclear whether the State intends to provide the same IDT to youth with substance abuse issues in accordance with the language of provision B.7.

During the November 2010 on-site tour, Dr. Glindmeyer observed an IDT meeting. In her report, she discusses that staff and youth appeared interested and engaged. We were pleased that important topics such as the youth's psychotropic medication were discussed in the meeting. Please see Dr. Glindmeyer's report for her full discussion. (See Glindmeyer First Mental Health Report at 14).

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

As discussed above, the lack of psychiatry staff participation in the IDT is troubling. We note that, prior to September 2010, psychiatrists participated in IDT meetings. We recognize that the psychiatry staff at Scioto is currently in flux and that the State is making efforts to replenish this staff. We strongly urge the State to make this a priority. Based on our review of the IDT documentation in youth records, we found that they were of variable quality. This may indicate a need for QA and re-training or simply reflect the strains from low staffing. We note that the proposed draft policy also has new documentation requirements. We look forward to reviewing this during our next compliance tour.

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 behavioral 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.* (See Consent Order III.B.8)

In order to assess this provision, we reviewed the State's self-assessment, draft policies and procedures, youth records and interviewed staff. Based on this review, we found the State's current multi-level process to compose youth's treatment plans to be confusing. It is our understanding that the State is currently revising this process, and we support the State's plan to integrate the three processes into one method. Similar to our discussion in provision B.6, it is troubling that, after two and a half years, the State has yet to make any substantive progress in creating an integrated treatment plan for youth with mental health, behavioral health and/or substance abuse needs. The State is non-compliant with this provision.

Compliance Rating: Non-Compliance

Recommendation(s) to reach substantial compliance:

We recommend that the State consider the recommendations made by Dr. Glindmeyer in her report regarding the new IDT plan model. (See Glindmeyer First Mental Health Report at 16). In addition, we remind the State that its IDT plans should also be available to youth with substance abuse needs. We look forward to reviewing the new policies, procedures, and practices during our

upcoming tour. We encourage the State to detail in its self-assessment (both oral and written) how the new IDT plan model meets the language of provision B.8.

B.9 ACCESS TO A QUALIFIED MENTAL HEALTH PROFESSIONAL

> *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. (*(See Consent Order III.B.9)

In order to assess this provision, we reviewed the State' self-assessment, policies and procedures, and youth records. Based on our review, we found that the current policies and procedures for referrals detail steps for staff to refer youth for a mental health assessment. The policy did not, however, address the requirements in provision B.9, namely that Scioto youth be able to seek access to a QMHP in a timely manner. In its self-assessment, the State relies on particular language in the Youth Handbook which directs a youth to complete a "Request for Services" for routine concerns and to immediately tell a staff member if they feel like hurting themselves or others, and the staff member "will see the issue is addressed." While we recognize that Scioto has readily available "Request for Services" forms, we are concerned by the generic and vague description of staff's role in obtaining assistance for the youth. More importantly, we share Dr. Glindmeyer's concern that youth must go through staff in order to access care. (See Glindmeyer First Mental Health Report at 19).

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

While the State appears to have a detailed process for staff to refer youth to a QMHP, there does not appear to be a self-referral process that does not rely on staff involvement. We recommend the State revise its policies as needed and seek technical assistance.

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. (See Consent Order III.B.10)

In order to assess this provision, we reviewed the State's self-assessment, relevant draft policies and procedures, and 16 youth records. At the time of the November 2010 monitoring tour, the facility employed two mental health units on campus: one designated for female youth (the Davey Unit, capacity 12 youth), the other for male youth (the Buckeye Unit, capacity 18 youth). According to the State's self-assessment, there is policy and procedure entitled "Mental Health Referral, Evaluation, and Disposition." This policy "identifies the process for consideration and referral for mental health treatment, including placement on a mental health unit when determined to be necessary." The State provided an additional draft policy entitled "Behavioral Health-Special Services Living Units," which provides "guidelines for the referral of youth identified through clinical assessment as needing specialized housing and programming for the stabilization of the symptoms of an identified mental illness and program modifications due to cognitive and/or developmental limitations." This policy proposed the development of a "Behavioral Health Review Panel," which would be responsible for "review[ing] information obtained in the reception process and determin[ing] the best options for each youth in regard to housing, programming." While we cannot yet determine the efficacy of these draft policies, the adoption of a review panel would be a positive step. See B.1.

Youth records included Reception Assessment Summaries that documented the State's housing determinations. A review of documentation provided for youth 999 included the Reception Assessment Summary created June 25, 2010. Staff recommended that the youth be placed in the "Intensive Mental Health Unit."

Following completion of intake, this youth was transferred to the Davey Unit. A review of documentation provided for youth 220 included the Reception Assessment Summary created February 16, 2010. Staff recommended that youth 220 be "consider[ed] for Intensive Mental Health Unit." This youth is currently residing on the Davey Unit; however, it was difficult to discern via records provided if this residence occurred immediately following the completion of the intake assessment. Review of additional youth records provided for off-site review revealed similar recommendations with youth placement in mental health units. "Mental Health Transfer Fact Sheets," which outlined the youth's specific treatment needs, accompanied these recommendations. It was apparent that mental health staff make housing recommendations during the intake/assessment period based on the results of the youth's assessment.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

While the youth placed in the mental health unit were appropriately placed, it does not appear that the State has implemented a system – supported by final policies and procedures – for ensuring that significantly mentally ill youth are provided appropriate housing and supports. The State should continue to implement the relevant draft policies and procedures, including the development of the proposed "Behavioral Health Review Panel." We also encourage the State to consider QA measures to review the accuracy and completeness of its assessments and placement decisions.

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.* (See Consent Order III.B.11).

In order to assess this provision, we reviewed the State's self-assessment, relevant policies and procedures, 16 youth records, and staff schedules, and we interviewed staff. Based on our review, we determined that there are staff shortages at the Scioto facility that are compromising youth's mental health care. The administrative psychiatrist (board certified in child and adolescent psychiatry) has been providing one day of direct clinical services per week (0.2 Full Time Equivalent ("FTE")). The State recruited a second psychiatrist to provide 20 hours of direct clinical services per week (0.5 FTE) via an emergency services agreement. At the time of the November 2010 on-site tour, the facility was stretched with regard to psychiatric resources, as it then had a total of 0.7 FTE and was in the process of recruiting additional staff. Unfortunately, the State did not provide the curriculum vitae ("CV") of the current psychiatric staff; so we cannot assess their qualifications at this time.

Prior to September 30, 2010, the facility had two psychiatric physicians (a total of 1 FTE) providing care. It is our understanding that the two individuals resigned. Once new staff are hired and in place, the State should determine whether 1 FTE of psychiatry will be sufficient to meet the facility's needs. These needs include psychiatric evaluation, medication management, participation in IDT team, administrative responsibilities, and emergency management. We recognize that the Scioto psychiatry and psychology staff are making a great effort to compensate for losing staff members. To be clear, the current stress on staff is not a sustainable long-term solution.

With regard to psychology, the State's self-assessment reported a total of four psychologists and five psychology assistants on staff. According to interviews conducted during the November 2010 facility tour, Scioto employs a total of seven psychologists (three licensed), a psychology supervisor, and two psychology assistants. Of the seven psychologists, five were assigned to the assessment units, the remainder to the program units. Dr. Glindmeyer's interviews with staff revealed unmanageable caseloads. (See Glindmeyer First Mental Health Report page 22). Other staff noted concerns regarding the quality of treatment being provided to youth. Specifically, staff reported that "things are moving so fast … knee jerk reactions … the treatment planning is unwieldy … it is too much for show and not enough for efficacy." We are very concerned about such comments.

The State's self-assessment reported a total of 18 social workers on staff. According to interviews conducted during the tour, there were a total of 14 social workers on staff, with 4.5 assigned to the reception units and 9.5 assigned to the program units. There was one vacancy in the social work staff. Interviews with facility staff revealed concerns regarding the quality of social work staff. Specifically, staff reported that "all the licensed [social workers] are leaving … because of the schedule changes." (See Glindmeyer First Mental Health Report page 23). Other interviews revealed that, until recently, there had been a lack of leadership in the social work division. It was reported that, in the first week of November 2010, a new supervisor was hired and began work at Scioto.

Additional mental health staff include mental health nurses and occupational therapists. At the time of the November 2010 tour, there were two full time mental health nurses providing services at Scioto, as well as two full time occupational therapists. Data regarding additional available FTE and current vacancies in these positions (if any) were unavailable at the time this report was authored.

According to observations and interviews, the current mental health divisions are not working together to create integrated treatment for the facility youth. At the time of the monitoring tour, three separate sets of documents existed to provide

guidance for a youth's mental health treatment: the Unified Care Plan, the Mental Health Treatment Plan, and the Interdisciplinary Treatment Team documents.

The State did not provide information regarding the integration of mental health and medical care in its self-assessment. Nor has the State provided data supporting a finding that there are adequate numbers of adequately trained direct care and supervisory staff to allow youth reasonable access to structured programming at this time. The State is in beginning compliance with this provision.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

According to staff interviews during the November 2010 tour, there are plans to begin use of an Integrated Treatment Plan beginning January 1, 2011. We hope that the State's implementation of the New Freedom Phoenix program, as well as the focus on behavioral health treatment modalities, including trauma-based treatment and cognitive behavioral therapies, will ensure that each youth has one overarching treatment plan and will help treatment providers form a cohesive treatment team unit. However, the State cannot reach substantial compliance with this provision until it recruits additional mental health staff and fills the current vacancies. The State should consider using objective data, such as workload indicators, to determine its staffing needs. In addition, the State must significantly improve coordination amongst the mental health staff in order to facilitate integrated treatment for Scioto's youth. Finally, in its next self-assessment, the State should provide CVs for all current mental health professionals, and evidence demonstrating the integration of medical and mental health care and demonstrating that there is sufficient direct care and supervisory staff to allow youth reasonable access to structured programming.

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 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 medication(s) 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 any request with DYS Legal Services prior to the approval for involuntary administration.* (See Consent Order III.B.12).

In order to assess this provision, we reviewed the State's self-assessment, relevant policies and procedures, and 16 youth records. According to the ODYS policy entitled "Psychotropic Medication, Use and Management," the State educates each youth and his or her parent or guardian about "the goals, risks, benefits, and potential side effects" associated with any medication prescribed by the physician. In addition, the prescribing physician provides an explanation of the potential consequences of not taking the medication and explains that the youth has an opportunity to consent or withhold consent to be treated. The policy also "provides guidelines within which medical professionals may petition the court to authorize involuntary administration of psychotropic medication."

A review of youth records revealed varying quality of documentation regarding risks, benefits, side effects and alternatives to treatment. The bulk of psychiatric documentation in youth records was attributable to prior treatment providers who ended their association with the facility September 30, 2010. The record of youth 999 revealed a psychiatric evaluation performed June 24, 2010, which documented a discussion consistent with obtaining informed consent with both the youth and her mother, inclusive of a documented review of some side effects. The youth completed a form entitled "Information about Medications for Youth with Mental Health Diagnoses." Although the information was incomplete, it

was apparently filled out by the youth and demonstrated some knowledge regarding side effects of the prescribed medications.

More recently, youth 110 received a psychiatric evaluation on October 8, 2010. There was basic documentation of informed consent. The records state that "risks, benefits, and side effects of medication were discussed. Consent was obtained by [sic] him, mom … was agreeable to medication as well." The "Information about Medications for Youth with Mental Health Diagnoses" form was included, and while completed, did not reveal a good understanding of potential side effects.

Youth 888 was admitted to the facility on October 12, 2010 and was prescribed psychotropic medication consisting of Geodon and Depakote. This youth's record included the "Information about Medications for Youth with Mental Health Diagnoses" form. It was incomplete in that it did not designate the diagnosis, did not identify specific side effects, and was not signed by the youth. The psychiatric evaluation performed at admission did not document review of informed consent issues, nor did it document contact with the youth's parent or guardian. While the documentation needs improvement, interviews with youth revealed that youth were able to name some of the medications prescribed and some side effects of the medications.

Finally, the documentation contained no information regarding petitions for authorizations to involuntary administer medications. Additional information regarding this issue will be requested for the next monitoring tour.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

While it is a positive sign that youth were able to name some of the medications prescribed and some of the side effects, the State must document that youth, and, to the fullest extent practicable and appropriate, his or her parent or caregiver, are informed of the goals, risks, benefits, and potential side effects of

medication. The State must also document that youth are given informed explanations of the potential consequences of refusing medication and that the youth have an opportunity to consent to such medication. The State cannot reach substantial compliance until it improves the quality and consistency of this documentation. We encourage the State to consider a peer review process for informed consent and other psychiatric documentation. In addition, the State should consider the development of information regarding side effects of psychotropic medication that is written in language that youth can understand. We note that such information is also available commercially.

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; and*
> b. *Not withhold the provision of psychostimulants to youth when such treatment is clinically warranted.* (See Consent Order III.B.13)

In order to assess this provision, we reviewed the State's self-assessment, relevant policies and procedures, lists of youth prescribed medication, mental health caseload documentation, and 16 youth records, and we conducted clinical observations and interviewed youth and staff. Scioto has a policy in place entitled "Psychotropic Medication, Use and Management," which "provides the parameters for using medication for psychiatric purposes … education addressing the goals, risks, benefits, and potential side effects associated with any given medication."

Scioto also has a document entitled, "Recommended Laboratory Monitoring Frequency Guidelines."

While the Consent Order requires the State to ensure that psychoactive medications are prescribed, distributed, and monitored properly and safely, psychiatric services at Scioto are limited. See B.11 ("Staffing"). Given the departure of the two long term psychiatric providers, and the lack of clinical resources, the psychiatry clinic at the Scioto facility was not fully functional at the time of the tour. According to staff interviews, the psychiatrists had been unable to attend interdisciplinary treatment team meetings, and were reduced to receiving "snippets of information for clinic from school, psychology and direct care." (See Glindmeyer First Mental Health Report at 27). Psychiatric administration reported that, as a "stop gap" measure, a noon meeting had been established between psychiatry and other disciplines for the purposes of reporting information and responding to staff queries.

As stated above, our review of selected youth records revealed that the majority of documentation was attributable to the prior treatment providers. In older files, psychiatric evaluations and progress notes documented the rationale for treatment with a specific psychotropic medication, the identification of target symptoms and discussions regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication, documented attempts or actual contact with a youth's parent or guardian, documented review of laboratory examinations and abnormal involuntary movement monitoring (youth 444, youth 555, youth 999). More recent psychiatric documentation was not as complete, in that there was no documentation of abnormal involuntary movement monitoring, laboratory review, or parent contact. This may be reflective of diminished clinical resources. Interviews with youth performed during the monitoring tour revealed that they had acceptable knowledge regarding their prescribed medication and potential side effects.

The psychiatrist reported taking after-hours calls for psychiatric emergencies at the facility. This report of on-call duty contradicted information

received from a document request, which indicated that psychiatry did not have on-call responsibilities at the facility. In addition, it was reported that there is no formal process for informing the psychiatrist when a youth is placed on suicide watch or other restriction. This is an area in need of improvement. The generally accepted practice is that the psychiatrist would be informed and aware that a youth on his or her caseload required enhanced supervision.

On the positive side, the psychiatrist reported good access to laboratory examinations following a physician order and good communication between the lab and the physician when abnormal laboratory results are found. The psychiatry clinic was observed during the monitoring tour, and the psychiatrist did a good job of establishing rapport with the youth. He queried the youth regarding side effects associated with a particular medication and also elicited information from the youth regarding expected medication benefits. The psychiatrist reviewed the youth's medical record inclusive of school and behavioral information.

During the clinic observation, the psychiatrist dictated clinical contact notes for three youth prescribed medication. However, the psychiatrist did not document the three youth's weight, vital signs, laboratory examinations, or the results of abnormal involuntary movement monitoring. This was concerning, as psychotropic medications can have serious metabolic side effects, and generally accepted practice requires monitoring of these and other parameters.

In the record of youth 555 there was an example of the sharing of information regarding medication compliance. This youth was reportedly planning to refuse medication due to side effects. This youth was seen five days following an email reporting his concerns. Given the current staff shortage at the facility, this is an acceptable delay; however, the facility should attempt to shorten the wait between a referral for services and actual clinical contact. This will require the recruitment of full time psychiatric staff.

At the time of the November 2010 tour, there were 141 youth housed on campus. Of these, 49 or 35%, were prescribed psychotropic medication. Of these,

ten were prescribed stimulant medications as a result of diagnoses including Attention Deficit Disorder ("ADD"), Attention Deficit Hyperactivity Disorder ("ADHD") or other Axis 1 mental health disorders. An additional two youth were prescribed Strattera, a non-stimulant medication used for the treatment of ADD and/or ADHD.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

We commend the State for ensuring that the psychiatrist has adequate access to laboratory examinations following a physician order and for maintaining good communication between the lab and the physician when abnormal lab results are found. However, in order to reach substantial compliance, the State must recruit psychiatric physicians to fill the available positions. Without sufficient mental health staffing, the State cannot ensure that psychoactive medications are prescribed, distributed, and monitored properly and safely, and consistent with generally accepted practices. The State should determine the number of FTEs required to perform necessary psychiatric duties, including clinics and attendance at treatment team meetings. In addition, we recommend that the State develop a formal process for informing the psychiatrist when a youth is placed on suicide watch or other restriction. We also recommend that the State improve psychiatric documentation and consider QA monitoring or a peer review process. Finally, it does not appear that the State is providing regular training to all health and mental health staff on current issues in psychopharmacological treatment as required by the stipulation. We strongly urge the State to devise a training schedule to meet this obligation.

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. (See Consent Order III.B.14)

In order to assess this provision, we reviewed the State's self-assessment, the training module curriculum, and other training documentation provided by the State. A review of the provided documentation regarding training revealed that the State provided the bulk of formal training prior to and during 2009. The State only conducted three trainings during 2010:

- Unit and treatment staff for the boys Mental Health Unit received six days of training in the strengths based behavioral management system ("SBMMS") and Mental Health Treatment in Corrections prior to the inception of this Unit in 2010;
- Staff on the girls Mental Health Unit received training on Borderline Personality Disorder in 2010; and
- All facility staff received training in "Understanding and Responding to Self-Inflicted Injury" and "Use of Mechanical Restraints for Psychiatric Purposes" in 2010.

The training documentation provided revealed that there was training entitled "Cognitive Disability Lesson Plan," which the State last provided in September 2009. The curriculum provided for this lesson plan referred to handouts. However, the State did not include the handouts in the documents provided, so a review of this training could not be performed. Training curriculum entitled "Axis II diagnoses" covered material regarding personality disorders and mental retardation. This curriculum was dated March 2010. This training material focused on the diagnostic characteristics for various disorders, and provided some tips for managing youth. For direct care staff, less diagnostic information and more management strategies would be beneficial. The State provided other training

modules from the National Center for Mental Health and Juvenile Justice for review. Unfortunately, in its self-assessment, the State did not provide a spreadsheet or list of staff attendance and training completion. We have included this in the document request for the upcoming monitoring tour.

In its self-assessment, the State referred to trainings that took place as early as 2006 – two years prior to the US v. Ohio Consent Order. In a recent investigation by the Chief Inspector's Office ("CIO"), Deputy Superintendent of Program Services, Nan Hoff, reported that Scioto has not offered training on how staff should work with the female youth population in about 3-4 years. (See Second Compliance Report, Attachment D). Finally, the State described additional informal efforts by facility mental health staff to provide educational/training opportunities to other facility staff via providing articles for their perusal. While informal efforts at increasing staff knowledge are laudable, they cannot take the place of formal training.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

The goal of this provision 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 a 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 (e.g., a youth diagnosed with ADHD may not respond the first or even second time that staff 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.

While the trainings the State provided in 2010 are a start, they are not sufficient to meet the requirements of this provision. The State should make an appraisal of its staff training needs and develop a curriculum to address these needs. Based on that appraisal, the State should continue the development of Mental Health Unit training and develop a mandatory training schedule for staff who provide care to youth on the mental health case load.

Unfortunately, in its self-assessment, the State did not provide a spreadsheet or list of staff attendance and training completion. Accordingly, we cannot assess the level of staff participation in the State's training programs. Going forward, the State should create a spreadsheet that delineates staff attendance and completion of required training modules.

B.15 STAFF MENTAL HEALTH TRAINING

The Facilities shall train:

a. *All staff who directly interact with youth (e.g. JCO's, 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.* (See Consent Order III.B.15)

In order to assess this provision, we reviewed the State's self-assessment, the training module curriculum, and other training documentation provided by the State. The State's policy entitled "New Employee Orientation and Basic Academy Training" outlines specific pre-service training topics for new staff. These include

basic mental health information: diagnosis, specific problem behaviors, psychiatric medication, recognition of signs and symptoms of mental illness and response to trauma, teenage development, strength-based treatment strategies, suicide, and others.

The State provided specific training modules for review in preparation for this monitoring report. These included: "Suicide Precautionary Equipment and Restraints"; "Understanding and Responding to Self-Inflicted Injury"; "Training Module for Girls Programming"; "The interface between the Juvenile Justice and Mental Health Systems"; "Psychopharmacology"; "Staff Roles and Responsibilities"; Therapeutic Milieu"; "Verbal Strategies"; "Axis II Diagnoses"; and modules from the National Center for Mental Health and Juvenile Justice, including "The Developmental Process", "Mental Health Disorders", "Treatment of Youth with Mental Health Disorders." The in-service training provided in 2010 is listed above in provision B.14. Given the State's planned addition of trauma/grief based treatment, and focus on creating a trauma based treatment environment, increased training regarding this subject matter is needed.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

As stated in the previous provision, the State should appraise its training needs, continue the development of Mental Health Unit training, and develop a mandatory training schedule for staff that provide care for youth on the mental health case load. In addition, the State should create a spreadsheet that delineates staff attendance and completion of required training modules.

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. (See Consent Order III.B.16)

In order to assess this provision, we reviewed the State's self-assessment, the relevant policies and procedures, and the data graphs regarding suicide prevention. We reviewed the provided policy and procedure entitled "Suicide Prevention and Response." Additionally, according to the State's self-assessment, the State is preparing to implement a revised policy entitled "Behavioral Health Services," which was in draft form at the time of the November 2010 tour. Once these revised policies are fully implemented, ongoing monitoring to ensure consistent implementation of policy and procedure will be necessary. Scioto collects statistics regarding facility wide suicidal behavior, as part of the monthly Psychology Director's report. The State provided these statistics/graphs for our review. Unfortunately, poor copy quality rendered them illegible. During the upcoming tour, we intend to examine any reports, quality assurance measures or data the State has collected regarding suicide prevention with respect to this paragraph.

Compliance Rating: Non-compliance

Recommendation(s) to reach substantial compliance:

At this time, the State has not provided us with sufficient information to determine that the State has begun to comply with this provision. The State should implement its draft policy regarding Behavioral Health Services and review any quality assurance and suicide prevention efforts in place. We ask that, in its next Self-Assessment, the State provide readable data regarding suicidal behavior and any final policies or procedures regarding suicide prevention. In addition, as stated under provision III.B.13, the State should improve communication with the psychiatrist when a youth requires placement on suicide watch or enhanced supervision.

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.* (See Consent Order III.B.17)

In order to assess this provision, we reviewed the State's self-assessment, ten medical release summaries, and six psychological service summaries used as part of transition and discharge plans, and we interviewed staff. In the medical release summaries, staff document youth's mental health diagnosis, current medication regimen, and what follow up community appointments have been recommended and/or scheduled for the youth. Based on our review, we have determined that these documents are not consistent with generally accepted practices. The ten medical release summaries we reviewed lack information regarding the need for ongoing mental health counseling or the types of treatment that the treatment team is recommending. Mental health staff does not included information regarding educational or other needs in the release summaries. For example, in the case of youth 111, discharged on August 2, 2010, Scioto staff prescribed the medications Lithium and Depakote at discharge. However, staff did not note the youth's diagnosis on the medical release summary. In addition, mental health staff prescribed the medication for "psych issues" and recommended psychiatry follow-up, but did not include referral resources in the medical release summary. Youth 222 was prescribed Zonegran and Sertraline for "psych problems." (See Glindmeyer First Mental Health Report page 34). Again, mental health staff recommended psychiatry follow-up; however, they did not include any referral resources in the medical release summary. Youth 333 was prescribed Risperdal and Prozac for "psych dxs." (See Glindmeyer First Mental Health Report page 34). Again, while staff recommended psychiatry follow-up, they did not include any referral resources in the medical release summary. In the remaining medical release summaries we reviewed, staff identified prescribed medications and listed diagnoses. However, staff recommended psychiatric follow-up, but failed to document resources.

In addition to medical release summaries, the State includes psychological service summaries in its transition and discharge plans. According to youth 111's psychological service summary, the youth had a history of experiencing severe mental health symptoms during his stay at Scioto. This culminated in an inpatient psychiatric hospitalization. Diagnoses for this youth include mental retardation. However, staff did not document the method by which this diagnosis had been obtained, or the required IQ and adaptive functioning scores required to meet criteria for this particular diagnosis. The psychological service summary includes a section entitled "plan/recommendations." Recommendations consisted of "wrap around services…connection with MRDD services … support for the family." (See Glindmeyer First Mental Health Report page 34-35). Unfortunately, staff did not recommend any specific treatment modalities or provide specific resources. Of the six psychological service summaries we reviewed, four offered generic recommendations similar to those proffered for youth 111. The other two summaries were more individualized and inclusive, providing some detail regarding the youth's specific needs.

According to the State's self-assessment, the policy governing this provision entitled "Behavioral Health Services" is currently in draft form, pending approval and implementation. Staff interviews conducted on-site revealed plans to implement a "discharge summary" for youth transitioning out of the facility beginning January 1, 2011.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

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 so that youth can access follow up care without an interruption in medication treatment. The State must significantly improve the quality of youth's transition

planning before it can reach substantial compliance with this provision. In addition, the State must implement and monitor the efficacy of Revised Policy 404.01 Behavioral Health Services and finalize the policy and procedure regarding transition/discharge planning.

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.* (See Consent Order III.B.18)

In order to assess this provision, we reviewed the State's self-assessment, and a monthly report, and we interviewed staff. According to the State's self-assessment, the psychology supervisor is providing a monthly report of the status of service delivery at the facility. The State provided an electronic copy of one such report for our review. The monthly report was not dated. However, it indicated that the previous psychiatric treatment providers were providing services and, as stated earlier, their tenure at the facility ended in September 2010. Nevertheless, the monthly report provided information regarding the number of youth admitted and discharged from the facility during the reporting period, the number of youth assigned to the mental health caseload, specific caseload numbers for psychology staff, the total number of available psychiatric clinical hours, the number of youth housed at the facility who are prescribed psychotropic medication, the number of youth receiving involuntary medication or requiring inpatient hospitalization, the number of critical suicide attempts, the number of missing or late treatment plans, the number and length of psychiatric contacts with youth, and any training provided to mental health staff. The monthly report does not specifically provide QA monitoring and the required assessment of the overall efficacy of the staffing, treatment and interventions utilized at the facilities.

The State provided draft policies regarding Quality Assurance and Clinical Supervision. However, the State did not provide the relevant policy or procedure in final form. Accordingly, it was difficult to determine the current requirements for QA monitoring.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

At the time of the November 2010 monitoring tour, the New Freedom Phoenix program had not yet been implemented. Given the State's planned implementation of expanded services, QA monitoring is currently in flux at Scioto. In order to move towards substantial compliance, the State must complete staff training and implement the New Freedom Phoenix program and other planned mental health treatment programs. Following the implementation of these programs, the State should begin QA monitoring to assess the efficacy of staffing, treatment and interventions. Finally, the State should provide the United States with finalized policies and procedures relevant to this paragraph for review.

NEXT TOUR AND COMPLIANCE REPORT

The United States intends to conduct a compliance tour of Scioto on February 22-24, 2011, with our expert Dr. Daphne Glindmeyer on-site and Dr. Kelly Dedel off-site. Our goal is to provide a third complete compliance report, based on the February 2011 compliance tour, to the Court on or before May 9, 2011.

Respectfully submitted this 16th day of February 2011.

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