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.	)	
	)	

THIRD 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 third report of its assessment of the State of Ohio's ("State") compliance with the June 5, 2008 Consent Order. For each substantive provision of the Consent Order, 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 in attaining substantial compliance with a particular provision.

This compliance report represents the United States' assessment of the State's compliance with all the provisions of the Consent Order, which relate to Ohio Department of Youth Services ("ODYS") policies, procedures, and practices governing the protection of youth from harm, mental health care, general medical care, grievances, special education, programming, and documentation for youth at the Scioto Juvenile Correctional Facility ("Scioto"). The Third Compliance Report is organized in this order and follows the structure of the Consent Order.

The United States based its assessment on document review (including, but not limited to, policies, procedures, training documents, youth records, incident reports,

grievances, medical records, and education documents), expert reports from Drs. Kelly Dedel, Michelle Staples-Horne, and Daphne Glindmeyer, youth interviews, and an on-site compliance tour on February 22-24, 2011. We have attached to this compliance report the expert reports[1] of Drs. Dedel, Staples-Horne, and Glindmeyer. Consistent with the U.S. v Ohio Consent Order, the United States provided the State with a draft version of this Compliance Report and expert reports two weeks[2] prior to filing with the Court. On April 26, 2011, the State provided the United States with its comments to the draft third compliance report. In sum, the State disagrees that any current and ongoing violations of federally protected rights have been identified in the draft third compliance report.

EXECUTIVE SUMMARY OF COMPLIANCE RATINGS

We report that of the 53 provisions in the U.S. v. Ohio, the State has achieved substantial compliance[3] with 39.62% (21 provisions), partial compliance with 30.18 % (16 provisions), beginning compliance with 28.30% (15 provisions), and non-compliance with 1.88% (1 provision). Overall, the State faces the greatest

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[1] Dr. Dedel prepared her third Protection From Harm ("PFH") report ("Dedel Third PFH Report") and her second special education report ("Dedel Second SPED Report"), labeled as Attachments A and B respectively. Dr. Glindmeyer prepared her Second Mental Health Report ("Glindmeyer Second Mental Health Report"), labeled as Attachment C. Dr. Staples-Horne prepared her Second General Medical Care Report ("Staples-Horne Second Medical Report"), labeled as Attachment D..

[2] On April 8, 2011, the United States sent the State a draft version of the compliance report and expert reports. The draft version did not include mental health. The United States provided the State the mental health portion of the draft third compliance report on April 13, 2011.

[3] "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.

challenges in the area of mental health, where the bulk of the provisions (77.77%) were rated as being in beginning compliance. This is due in part to challenges in maintaining sufficient mental health staff. The State is actively recruiting new mental health staff, in particular psychiatrists. The State has demonstrated strong improvement in medical and special education and is compliance with 80% and 72.72% of those provisions, respectively. We recognize and commend the State's progress and significant efforts to date in working towards achieving substantial compliance with all the provisions in the Consent Order. We note, however, that ODYS recently announced the closing of the Ohio River Valley Juvenile Correctional Facility ("ORV"), which most likely will result in at least some youth being transferred to Scioto. Accordingly, the State should begin to prepare now for the increase in population and with it an increase in demand for mental health, medical, and special education services.

The chart below represents the most recent compliance rating and percentage of type of compliance for each subject matter area of the U.S. v Ohio stipulation. A detailed discussion is provided throughout the remainder of this compliance report.

COMPLIANCE RATINGS

	Substantial	**Partial**	**Beginning**	**Non Compliance**
Protection From Harm	57.4% (4 provisions)	42.85% (3 provisions)	N/A	N/A
Mental Health	N/A	16.66% (3 provisions)	77.77% (14 provisions)	5.5% (1 provision)
Medical Care	80% (8 provisions)	20% (2 provision)	N/A	N/A
Special Education	72.72% (8 provisions)	18% (2 provisions)	9% (1 provision)	N/A
Programming	N/A	100% (2 provisions)	N/A	N/A
Grievances	33.3% (1 provision)	66.6% (2 provision)	N/A	N/A
Documentation	N/A	100% (2 provisions)	N/A	N/A
TOTAL:	39.62% (21 of 53 provisions)	30.18% (16 of 53 provisions)	28.30% (15 of 53 provisions)	1.88% (1 provision)

I. PROTECTION FROM HARM

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.* (See Consent Order III.A.1)

In assessing this provision, we reviewed the State's self-assessment and documents requested prior to tour, and interviewed youth and staff. Based on our review, we were again impressed with the level of detail and effort reflected in the State's assessments regarding youth violence, use of restraint, use of seclusion, and allegations of child abuse. In our Second Compliance Report, due to the increase in youth violence at Scioto, yet decrease in such violence at other ODYS facilities, we recommended the State focus on interpreting the data it collects to determine trends and root causes. In her second report, Dr. Dedel suggested that the State discern the underlying causes of the increase in youth violence and enact specific strategies to address conditions that may provide the opportunity for violence. In late 2010, the State undertook such analysis and, in summary, found that a combination of workforce stability issues (fluctuating staffing levels for social workers, unit managers, psychologists and psychiatrists) and the lack of special management plans for certain specific youth were collectively responsible, at least in part, for the increase in violence. The State is to be commended for its prompt and exemplary efforts towards investigating the source for the increase in violence. Most importantly, once the State uncovered these causes, it then instituted changes/steps to begin to address the problems. (See Dedel Third PFH Report at 4-5). We commend the State for its efforts and success.

As noted above, provision A.1 of the U.S. v. Ohio Stipulation requires the State to "ensure that youth are protected from abuse and neglect, use of excessive force, undue seclusion, undue restraint, and over familiarization." On February 25, 2011, Drs. Dedel and Glindmeyer provided exit briefings about their preliminary

findings based on the February 2011 compliance tour. In a separate call, on that same day, the United States informed the State of general concerns it had based on interviews with Scioto youth in February 2011. Through a letter dated March 11, 2011, the United States memorialized the same concerns. Due to the nature and importance of these allegations we note them for the Court below.

During the February 2011 compliance tour, the United States visited six housing units and interviewed 25 youth.[4] Our interviews indicated that many Youth Specialists ("YS") engage professionally with youth and care about their well-being. Also, most Chief Inspectors Office ("CIO") investigations about alleged abuse and neglect investigations about YS staff are generally well done. (This is discussed in further detail under provision A.5.) However, and deeply troubling, our youth interviews indicate that a significant number of YS staff manifest indifference to the risk of being held accountable for mistreating youth. The allegations we received indicate that cultural change at Scioto is incomplete, and that significant shortcomings remain in the State's ability to protect Scioto youth from harm.

The United States does not endeavor to corroborate each of the allegations identified. However, the general consistency of the allegations, the existence of corroborating evidence in some cases, and the documented high rates of staff noncompliance with basic safety checks (discussed under section A.3 below) are strong evidence that supervision and accountability of staff at Scioto are insufficient to protect youth from harm. Contributing to this problem is a widespread distrust in the grievance process (discussed under sections D.1 and D.2 below).

Among the allegations that we received from youth at Scioto are that some YS staff:

[4] The 25 youth represent approximately 18% of the youth at Scioto during the February 22-24, 2011 tour.

- Attempt to enter sexual relationships with youth and engage youth in discussions about sexual activity;
- Intentionally provoke youth by taunting them and then "write them up" for fighting;
- Threaten youth not to cooperate with investigations by the CIO or Scioto investigators;
- Berate or talk down to youth by calling them inappropriate terms such as "bitch," "ho," or "retard," or talk inappropriately about their mothers; and
- Bribe youth with food, snacks, or extra free time in exchange for services by the youth. These services include writing a grievance against a disfavored YS or attacking or fighting a disfavored youth.

The United States recommended to the State that Scioto administration remind all staff (YS, medical, mental health, recreation, etc.) that mistreatment of youth will not be tolerated and that all staff are responsible for reporting their colleagues if they witness such behavior.

In the same March 11, 2011 letter, we also described problems with third-shift supervision not executing their rounds, delays in receiving medical care (sick calls filled), the quality of mental health care remaining significantly below minimum standards required by the Consent Order, and complaints from youth that they spend an inordinate amount of time engaged in activites such as playing cards or locked up in their rooms. We discuss these issues throughout this compliance report.

Since provision A.1, "General Protection From Harm," is composed of the subject areas in provisions A.2-A.7 (Use of Force, Seclusion, Restraint, Investigation of Serious Incidents, Staff training, and Employment Practices), compliance in A.1 is dependent upon the State's achievement of substantial compliance with all PFH provisions. As noted above, the State faces challenges with provisions A.3 (Seclusion) and A.5 (Investigation of Serious Incidents). This is consistent with our Second Compliance Report based on our tours in October and November 2010. We discuss both provisions below.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

The State must actively address its failure to comply fully with provisions A.1, A.3 and A.5. Specifically, the State needs to address the belief among some YS staff that they will not be held accountable for mistreating or threatening to mistreat youth (A.1 prohibits abuse and neglect of youth), and ignoring their duty to conduct security checks (required by provision A.3). The State also needs to improve the quality of investigations regarding alleged staff misconduct and address any retaliatory threats by YS staff against youth for cooperating in investigations (required by provision A.5). These are chronic problems that the United States described in its findings letter to the State in 2007. To be clear, until the State addresses these serious risks to the youth under its custody, it will not reach substantial compliance with provision A.1.

A.2 USE OF FORCE

> *The State shall develop and implement comprehensive policies, procedures, and practices limiting use of force on youth to situations where it is objectively reasonable and necessary. Staff shall be required to adequately and promptly document and report all uses of force.* (See Consent Order III.A.2)

In our assessment of this provision, we reviewed the State's self-assessment and documents requested prior to tour, and interviewed youth and staff. Consistent with our Second Compliance Report, the State is in substantial compliance with this provision. We commend the State for maintaining its compliance rating.

Based on our review, the State's frequency of training in Use of Force ("UOF") continues to exceed that of generally accepted practices and relevant policies and procedures continue to meet the language of provision A2. Similar to our November 2010 compliance tour, we determined that the State undertakes various efforts to ensure that UOF occurrences were promptly and completely documented. In our Second Compliance Report, we described the appointment in Fall 2010 of a Facility Intervention Administrator ("FIA") to conduct internal

reviews of all UOF incidents. The FIA determines whether the documentation meets ODYS policy requirements, whether staff require additional coaching or training regarding documentation, and whether the incident should be referred for investigation. Separately, each incident is also reviewed by the Operations Administrator and the Deputy for Direct Services. Ten percent of the UOF incidents are also reviewed by the Superintendent. This activity unquestionably reflects a serious and thoughtful effort to ensure that all incidents of UOF on youth are limited to situations in which it is objectively reasonable and necessary. We note that two incidents we learned about from youth during the February 2011 tour and brought to the attention of the Deputy for Direct Services had already been identified for investigation internally by Scioto.

We agree with Dr. Dedel's suggestion that the State should investigate the cause for the reduced rate of physical restraint for the period August 2010 to January 2011 as compared to February 2010 to July 2010. We believe that such analysis could be helpful to the State in its own long-term goal of sustaining all the improvements it has accomplished thus far. (See Dedel Third PFH Report at 6). As mentioned by Dr. Dedel, youth who resided at Scioto in the past and who had recently returned noted that direct care staff now consistently attempt to de-escalate youth acting out prior to attempting a physical restraint. (See Dedel Third PFH Report at 7). This is an important factor in protecting youth from harm and we commend the State on its continued success.

Compliance Rating: Substantial Compliance

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.* (See Consent Order III.A.3)

In our assessment of this provision, we reviewed the State's self-assessment and documents requested prior to tour, and interviewed staff and youth. Based on our review, we found that the State continues to demonstrate reduced rates of all types of seclusion (regular, pre-hearing confinement, and disciplinary). As detailed in Dr. Dedel's report, during the period from August 2010 to February 2011, almost one third of the youth placed in regular seclusion (which can last between 1 to 3 hours) were placed for less than one hour. For youth who engaged in violent misconduct and were placed in pre-hearing seclusion, approximately 80% were not required to remain secluded pending their disciplinary hearing. For the same time period from August 2010 to February 2011, the use of disciplinary seclusion has been low when compared to the number youth on youth incidents. Dr. Dedel found that disciplinary seclusion was imposed in about 60% of the incidents and the remaining 40% of the youth received an alternative consequence. (See Dedel Third PFH Report at 8). We commend the State for its success in limiting the different types of seclusion. We do suggest that more thought be given to the types of alternative consequences. For example, while some youth are tasked with writing an apology letter to another youth they assaulted (a constructive and meaningful act) other youth reported that they are easily and frequently subjected to sanctions such as repeatedly (hundreds of times) writing the facility rules, an act that has limited if any redeeming value or benefit to the youth.

Consistent with our findings in our Second Compliance Report, the State's success with this provision is undercut by failures by some third shift staff who inconsistently monitor youth during the nighttime. During the February 2011 tour we received complaints from youth alleging that YS staff on the third shift were not conducting their nightly watches as required. In February 2011, we received multiple complaints that some third shift (10:00 p.m. to 6:00 a.m.) staff ignore youth who want to use the bathroom. A few youth further alleged that they or other youth they know have resorted to urinating on the floor of their room or on themselves because third shift staff did not open their room door soon enough. Youth made

similar allegations in their grievances for the time period November 1, 2010 to February 1, 2011. We heard similar complaints in November 2011, when youth alleged that staff did not conduct their watches because they were too busy watching television. We appreciate the State's efforts to resolve this problem—such as cutting cable programming signals to television sets after 11:00 p.m. and increasing the number of random videos they check weekly from one to two—but ultimately the problem is one of supervision and accountability. This is illustrated by recent allegations from numerous youth that some third shift staff have simply switched to watching DVDs instead of television programs.

In order to corroborate these allegations, during our February 2011 compliance tour, we asked to see three randomly selected third shift videos. The United States viewed these videos with the State's counsel and the Deputy for Direct Services. One of the three third shift videos demonstrated that the only YS staff member assigned to the unit performed no checks at all from 12:00 a.m. to 6:00 a.m. The State indicated that it would check the video footage from the beginning of the shift (reportedly 10:00 p.m.) until 12:00 a.m., but any checks during that two-hour period would not negate the dereliction of duty observed for a full six hours. While the other two randomly selected videos demonstrated staff appropriately conducting their rounds, it appears that the State's current efforts to deter YS staff from ignoring their duties are still falling short. On April 6, 2011, the United States received a response letter to the March 11, 2011 post-tour letter thanking the United States for its recommendations and stating in part that "[a]dditional time, effort, and resources will be needed to determine exactly what improvements are most appropriate for the youth at Scioto JCF, and how best to implement them." We did not receive any further information regarding the two-hour period of the video watched in which no checks were performed.

With regard to security checks conducted in general, Dr. Dedel notes that during the time period from November 1, 2010, to February 1, 2011, eight of the 17

shifts (47%) randomly checked by Scioto administration evidence some problem with staff completing safety checks of youth in their rooms. (See Dedel Third PFH Report at 9-10).

As Dr. Dedel discussed in her first and second PFH reports, anytime a youth is placed behind a closed door, the risk of self harm increases. (See Dedel Second PFH Report at 13). A youth who is intent on harming himself will keep track of when staff conduct their checks and act as soon as the staff member moves on. For this reason, long gaps between monitoring checks are of great concern and must be addressed immediately. Since the State has not improved its monitoring of youth during bedtime hours it has not met the language in provision A.3 and remains in partial compliance.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

As discussed above, in order to reach substantial compliance, the State must address the issues involving security checks during periods of seclusion and night time checks during third shift when youth are in bed. The State should also consider creating a set of approved consequences that are meaningful and appropriately calibrated to the severity of the youths' misconduct.

A.4 RESTRAINT

> *The State shall develop and implement policies, procedures and practices so that only safe methods of restraint are used at the facility and only in those circumstances necessary for safety and security and, to the extent possible, when less restrictive means have been properly, but unsuccessfully, attempted or with respect to therapeutic restraints pursuant to a medical order to protect the health of the youth.* (See Consent Order III.A.4)

In our assessment of this provision, we reviewed the State's self-assessment and documents requested prior to tour, and interviewed youth and staff. Based on our review, we found that the State has continued to strengthen its efforts to ensure

that staff are well-trained in safe methods of restraint and that the training results in positive results. In 2010, at least 90% of the Scioto direct care staff received all the required Managing Youth Resistance ("MYR") training. (See Dedel Third PFH Report at 11). We encourage the State to ensure that the remaining 10% of staff receive the MYR training in the near future. The MYR training is now required once a quarter rather than annually. In November 2010, Dr. Dedel reviewed 10 UOF incident reports previously reviewed by the State's internal auditing process and found that the reviews were appropriate. We understand that the internal auditing process has not been changed or modified. Lastly, when we interviewed youth, they generally corroborated that staff attempt to break up fights between youth first using verbal commands and if that fails, they intervene physically. The methods described by the youth appeared to be consistent with the MYR curriculum. We note that the ODYS policies and procedures for the use of restraint were in substantial compliance during our last review and remain the same. Accordingly, the State continues to be in substantial compliance with this provision. We commend the State on its continued success under this provision.

Compliance Rating: Substantial Compliance

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 staff 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.* (See Consent Order II.A.5)

In our assessment of this provision, we reviewed the State's self-assessment, documents requested prior to tour, and interviewed youth. Based on our review, we determined that, while the State's policies, procedures, and investigations manual appear to sufficiently address the investigatory process and timing and meet the

requirements of provision A.5., the level of investigations at the facility level continue to be lacking.

In our Second Compliance Report, we discussed our various concerns regarding a series of allegations by female youth about inappropriate sexual comments from male staff. In particular, we detailed how the facility administration appeared to be unaware of the allegations of inappropriate sexual comments from staff until we informed them, how the facility had allegedly lost or misplaced the youth's statement reporting the allegation, and how when CIO investigated the matter, they asked youth about privileged conversations the youth had with the United States. When we interviewed female youth during our February 2011 tour, we learned that since November 2010, Scioto staff have been more proactive about reporting and addressing instances of other staff exhibiting inappropriate relationships with youth. We are hopeful that Scioto's administration will aggressively pursue sanctions against staff who prey on any youth at Scioto, since such behavior is not only illegal, but contrary to the very rehabilitative purpose of Scioto.

While the State's policies and procedures have met the requirements of provision A5, its practices are not yet compliant with this provision. In her review of 15 investigations investigated from November 1, 2010 to February 1, 2011, Dr. Dedel found that the facility level investigations continued to be problematic. (See Dedel Third PFH Report page 12-13). Dr. Dedel notes that several of these investigations the investigatory protocol "lacked the necessary vigor to ensure a reasonable finding" and that two investigations were so poorly written that it was difficult for her to discern the basis for the investigator's conclusions.

For the same time period, there were four allegations of inappropriate relationships between staff and youth,[5] 10 allegations of inappropriate or excessive UOF, and one allegation of verbal abuse. (See Dedel Third PFH Report at 12). According to Dr. Dedel's review of these investigations, the CIO investigations were of high quality. Id. We are encouraged by the quarterly audits performed by the CIO and believe that they are instrumental in improving the quality of investigations from the CIO's office. We were also pleased to learn that the CIO plans to provide training to Scioto investigators.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

Consistent with our Second Compliance Report, we recommend the State regularly audit facility level investigations for completeness. Further, the State should take measures to remind its staff of the importance of relaying serious allegations to facility operations, whether youth convey these allegations orally or in writing. Lastly, we echo Dr. Dedel's recommendations to train all Scioto investigation staff on proper investigatory protocol, ensure that all investigations of employee misconduct and youth mistreatment meet generally accepted standards, and that the Staff provide feedback to youth about investigations that stem from an allegation or grievance about staff mistreatment. (This last point is discussed in further detail below in section D.2.) (See Dedel Third PFH Report at 13)

A.6 STAFF TRAINING IN BEHAVIOR MANAGEMENT, DE-ESCALATION MANAGEMENT, DE-ESCALATION AND CRISIS INTERVENTION

The facilities shall train all staff in behavior management, de-escalation techniques, appropriate communication with youth and crisis intervention before staff may work in direct contact with youth. (See Consent Order III.A.6)

[5] During our February 2011 on site tour, we interviewed youth who alleged that recently YS staff on their unit have propositioned youth and/or attempted to enter into sexual relationships with youth.

In order to assess the provision, we reviewed the State's self-assessment, documents requested prior to tour, and interviewed youth. Based on our review of these documents, we found that the State continues to be in substantial compliance with this provision. Consistent with our Second Compliance Report, the State's training and development program in this area exceeds generally accepted practice. Additionally, based on a review of training documents, Dr. Dedel found that in 2010 92% of veteran staff completed all 24 separate training courses. (See Dedel Third PFH Report at 14). In our Second Compliance Report, we assessed staff training with regard to the Strength Based Behavior Modification System ("SBBMS"). As of November 2010, 93% of the Scioto staff received the SBBMS training. While we did not assess this training during our February 2011 tour, we encourage the State to maintain its high rate of training. Overall, we commend the State on its commitment to staff training.

Compliance Rating: Substantial Compliance

A.7 EMPLOYMENT PRACTICES

> *The State shall use reasonable measures, including background checks and criminal records checks, to determine applicants' fitness to work in a juvenile facility prior to hiring employees for positions at the facility.* (See Consent Order III.A.7)

In our assessment of this provision, we reviewed the State's self-assessment and documents requested prior to tour. Pursuant to the relevant procedure, if a candidate is being recommended for employment after completing the screening and interview procedures, that candidate is required to pass a criminal background check prior to being employed. Candidates with various serious offenses are excluded from employment, while those with certain less serious offenses may be eligible pursuant to other requirements. During the period from November 1, 2010 to February 1, 2011, Scioto hired four new employees. All four employees passed their background check and did not have any criminal records for any offenses that would bar their employment according to ODYS regulations. Consistent with our

Second Compliance Report, the State has maintained its substantial compliance rating with this provision. We commend the State on the proper screening practices of prospective employees.

Compliance Rating: Substantial Compliance

II. 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 PowerPoint presentation, verbal self-assessment,[6] new draft policies and procedures, and youth records, and we interviewed youth. Based on our review, it appears that the new ODYS policies and procedures, "Mental Health Screenings," meet most of the requirements of provision B.1. Specifically, the procedure requires that a mental health trained or qualified mental health personnel ("QMHP") assess a youth's suicidal ideation, self injurious behavior, prescription of psychotropic medication, mental health issues, diagnoses, treatment and history of substance abuse within 24 hours of the youth's admission. However, the State's intake assessment documentation is of variable quality. (See Glindmeyer Second Mental Health Report at 2). Accordingly, while the relevant policy and procedure are consistent with the requirements of provision

[6] For the February 2011 compliance tour, the State elected to present a verbal self-assessment only. We encourage the State to produce a written self-assessment as it did for the November 2010 compliance tour as it will allow the State to satisfy its duty to demonstrate compliance. (See U.S. v Ohio Consent Order at IV.E (requiring the State to analyze and assess its compliance with each provision); (id. at V.H (requiring the Monitor to provide compliance reports that specify "the self-assessment steps the facility undertook to assess compliance and the results thereof.")).

B.1, the facility's practice has not yet reached full compliance. We further discuss the quality of the assessment documents in provisions B.3 and B.4.

In our Second Compliance Report, we explained that the State informed us that it intended to implement on January 1, 2011 a new policy, "Behavioral Health Assessment, Screening, Appraisal and Evaluation," which, as the name implies, would address different aspects of a youth's behavioral health assessments including screenings. The new policy included 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. During our February 2011 compliance tour, the State informed Dr. Glindmeyer that it intended to introduce a new "Behavioral Health Appraisal" document, which it had not yet been tested but expected to be fully implemented as of March 15, 2011. The State anticipates that "Behavioral Health Appraisal" document would provide improved case conceptualization and diagnostic clarification with recommendations for treatment. Based on the nascent nature of the appraisal document, it was not possible to assess its effectiveness. Accordingly, the State remains in partial compliance with this provision.

Compliance Rating: Partial Compliance

Recommendation(s) to reach Substantial Compliance:

We encourage the State to develop and begin quality assurance review of, or clinical supervision for, assessment summary documents. The State should fully implement all relevant policies, procedures, and forms related to mental health screenings.

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 PowerPoint presentation, verbal self-assessment, policies, procedures, and psychology staff schedules, relevant Ohio statute, and youth records, and we interviewed youth and staff. Based on our review, we found that the relevant policies and procedures adequately describe procedurally how and under what circumstances a referral is to be made. It appears that, in order to have 12-hour weekday and 8-hour weekend coverage, the State relies heavily on its psychology staff and requires the psychology supervisor to be on-call continuously. We strongly suggest the State consider seeking some form of staffing relief in order to account for staff illness, vacation, and unexpected absences. Further, in keeping with Ohio Rev. Code Sec. 4757.02(A)(5), the State allows unlicensed staff, such as social workers, to qualify as the qualified mental health professional ("QMHP") required by provision B.2. Given that Scioto lacks sufficient psychiatric staff to provide social workers with support and supervision, we are concerned that unlicensed staff serve as QMHPs.

Between November 11, 2010 and February 11, 2011, Scioto staff conducted capacity assessments of 26 youth. With one exception, staff completed the assessments on the same day as the request. Staff completed the remaining assessment within two days after the request. During the same period, intake staff referred 32 youth for risk assessments. Mental health staff conducted all of the assessments on the same day as the referrals. However, staff did not note the times of the requests and the assessments on the documentation, so we could not determine whether staff completed the assessments within the four-hour time frame required by the State's procedure. Finally, according to the State, only four youth submitted written requests for mental health services between November 11,

2010 and February 11, 2011. Staff saw all four youth within four hours of their requests.

We note that the information above does not include referrals for mental health interventions that other mental health staff generate. Going forward, it would be helpful for the State to keep track of those requests as well since, based on the documentation we received from the State, youth do not frequently request mental health services in writing. This issue is discussed in more detail under provision 9, "Access to Qualified Mental Health Professional."

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

The State should create quality assurance measures to ensure that all requests for mental health services by both mental health and other staff and provisions of services are made within the appropriate time frames.

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 PowerPoint presentation, verbal self-assessment, policies and procedures, and youth records, and we interviewed youth and staff. Based on our review, we found that the State has made little progress in meeting the requirements of provision B.3. In November 2010, the State's written self-assessment for provision B.3 did not address the identification of youth who were not previously identified as presenting mental health or behavioral needs requiring treatment. Instead, the State discussed the monitoring for decompensation of youth who are in seclusion, which is appropriate,

but insufficient. We agree with Dr. Glindmeyer that the goal of provision B.3 is to ensure that all 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" as clinically appropriate. (See Glindmeyer Second Mental Health Report at 5-6).

The State provided us with one example of a youth, Youth 330, who was placed in the general population upon her admission to Scioto in May 2010, but began to experience mental health symptoms fourth months later. While the State appropriately identified this youth as in need of mental health care, this example is not sufficient to establish that the State has made notable progress in achieving compliance with the key components of this provision. Specifically, due to the State's inadequate recordkeeping, we question the accuracy of the interventions the State reported in Youth 330's case. Specifically, once the youth began to decompensate in September 2010, staff conducted a mental health assessment, but staff did not document any treatment that Youth 330 received from late September through October 2010. Instead, on November 1, 2010 – the day before our compliance tour – staff entered approximately ten late mental health entries into this youth's chart. According to these late entries, the State provided this youth with generic, but ultimately sufficient care. Youth 330's health record reflected a disturbing pattern of mental health staff entering notes in youth records well after their contact with the youth actually occurred. Such a practice falls well below generally accepted standards of care, makes it impossible for staff to follow a youth's mental health treatment over time, and inhibits decision making. During our February 2011 compliance tour, facility staff candidly noted that they were aware of the need for ongoing and improved quality assurance to review documentation and the decision-making process regarding the mental health needs of youth. (See Glindmeyer Second Mental Health Report at 6).

We understand that the State is beginning implementation of its new policy,[7] "Behavioral Health Assessment, Screening, Appraisal and Evaluation." As of the time of the February 2011 compliance tour, the State had begun using the new policy and procedure to review assessments performed on Tuesdays, with the expectation of a complete expansion to review all intake assessments by April 1, 2011.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

As noted above, the State has not provided us with adequate information to determine that, in practice, it identifies and provides treatment to previously unidentified youth in a manner consistent with generally accepted professional standards of care. We recommend that the State ensure that the new draft policy regarding screenings, evaluations, appraisals, and re-evaluations captures previously unidentified youth, not merely youth in seclusion. The State must also ensure that staff complete documentation of mental health treatment provided to youth, including previously unidentified youth, in a timely manner. Late documentation does not have the richness of documentation completed immediately following a mental health contact. Finally, the State should engage in quality assurance monitoring regarding the reevaluation of youth who experience an exacerbation of mental health symptoms or behavioral challenges.

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

[7] 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.

> *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 PowerPoint presentation, verbal self-assessment, youth records, and ODYS policies and procedures, and interviewed staff and youth. Based on our review, we found that the State is currently performing mental health assessments and appraisals at intake/reception. The initial assessment summaries and mental health appraisal reviewed provided useful information for placement and initial treatment planning, but were of varying quality. During the State's verbal self-assessment, the State acknowledged that youth charts had not changed significantly since our November 2010 tour, with the exception of charts' increased fidelity to the subjective, objective, assessment, and plan ("SOAP") note format, more in-depth assessments, and possible inclusion of diagnostic criteria review and case conceptualization. (See Glindmeyer Second Mental Health Report at 7). Our review of recent intake assessments revealed that, while staff generate multiple assessment forms for youth, mental health staff's case conceptualization is still weak and the staff fails to tie all of the information obtained into a coherent package for the reader. Moreover, the intake assessments did not consistently provide a statement of specific diagnostic criteria justifying the diagnosis.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

We are encouraged to learn that the State has begun to establish clinical review teams to provide formal recommendations. The State should continue and expand its quality assurance measures to include a peer review process and clinical supervision. These quality assurance measures should be geared towards ensuring

that mental health staff accurately document all diagnostic formulations and develop a case conceptualization for each youth that ties together information obtained through the assessment process. (See Glindmeyer Second Mental Health Report at 7-8).

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

In assessing this provision, we reviewed the State's verbal self-assessment, youth records, ODYS policies and procedures, and descriptions of treatment modalities, observed three group interactions, and interviewed youth and staff. While the State has begun to implement its new mental health policies since our last review, the State has not yet made notable progress in achieving compliance with the key components of provision B.5. Specifically, in addition to the State's failure to develop adequate diagnostic formulations and case conceptualizations, detailed above, our review revealed numerous deficiencies with regard to the State's provision of treatment planning, individual therapy, group therapy, and the quality of Scioto's mental health staff.

The State reported during the February 2011 compliance tour that the New Freedom Phoenix program, which is the overarching treatment program for all Scioto youth, was fully functional in one housing unit and will expand into all units by April 1, 2011. All Scioto staff have completed the training required for the "Trauma and Grief Component Therapy for Adolescents." We observed the first group meetings for this group therapy on the boys and girls mental health units. The group leaders were well-prepared and effective and youth were engaged in the group process. (See Glindmeyer Second Mental Health Report at 9-11). Social work and psychology staff are working together to co-facilitate cognitive behavioral

therapy ("CBT") based groups. However, CBT trained YS staff demonstrated limited investment and involvement in the group process. This issue is discussed further under provision B.7, "Treatment Teams."

Although youth receive group therapy, the State has not demonstrated that youth are receiving adequate assessments and treatment through this process. Specifically, documents tracking youths' progress during group therapy were identical for several consecutive sessions, demonstrating that staff failed to conduct individualized assessments. We did not assess the mental health group notes for boys because the most recent documentation that the State provided us was from August 2010.

Our review of records related to individual therapeutic interactions, including individual counseling, revealed similar deficiencies. While psychology staff engage in and document crisis management, there is little evidence that they currently track youths' progress toward their treatment plan goals as they participate in individual therapeutic interactions. Nor do staff incorporate the treatment plan's specific targeted interventions into these individual sessions. We hope that the State will address these deficiencies as it moves towards developing an Integrated Treatment Plan ("ITP") for each youth.

Finally, administrative staff reported concerns about the quality of work provided by some members of the mental health staff, particularly with regard to documentation. The administrative staff estimated that three social workers were "not functional" and one psychology staff "lags behind." (See Glindmeyer Second Mental Health Report at 10). Administrators discussed plans to utilize the disciplinary process and performance evaluations in order to remedy these deficiencies.

Our review of documentation found that the quality of treatment plans varied. (See B.8 ("Integrated Treatment Plans")). According to the State's verbal

self-assessment, in recent months, Scioto staff diligently worked to complete treatment plans for youth in the new integrated format. Ongoing clinical supervision and quality assurance may be helpful for staff when adjusting to these new documentation criteria.

Despite these findings, we are encouraged by the fact that the State is already making strides towards improving its treatment program. Going forward, we look forward to learning about the full implementation of the New Freedom Phoenix program and any data the State can provide regarding the efficacy of the program. We also 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:

Consistent with our Second Compliance Report, we recommend that the State ensure that the documentation in youth records clearly articulates 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. In particular, staff should consistently track youth's progress towards their treatment plan goals as they participate in group and individual interactions. Staff should conduct meaningful, individualized assessments and, as recommended in B.4, the State should document all diagnostic formulations and develop a case conceptualization for each youth. The State should also ensure the provision of evidence-based group therapeutic interactions and ensure that rehabilitative and substance abuse services are included in the new treatment program. The State should also expand the group curriculum available to male youth and engage and encourage direct care staff to participate in group modalities.

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 verbal self-assessment, integrated treatment plans, and policies and procedures, and we interviewed staff. Based on document review and interviews with staff, we understand that, as of January 1, 2011, the State has begun to implement its interdisciplinary Treatment Team policy and its revised format for documenting treatment team planning by creating an "Integrated Treatment Plan." As discussed further in provision B.7 below, it appears that there was limited psychiatrist attendance at IDT meetings. While this is an improvement since our last compliance visit in November 2010, this remains problematic.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

We encourage the State to complete the Integrated Treatment Plan for all youth and begin quality assurance monitoring of the treatment planning process to ensure that treatment teams operate in an interdisciplinary fashion, with sufficient participation by all relevant disciplines, to generate a single, integrated treatment plan that meets the youth's needs. (See Glindmeyer Second Mental Health Report at 12). We also recommend that the State 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 youth records, Interdisciplinary Team ("IDT") meeting minutes, observed group therapies and treatment teams, and interviewed youth and staff. Based on our review, it appears that the State's newly implemented standard operating procedure, "Interdisciplinary Team," 404.02.01, meets the requirements of provision B.7. Previously, the procedure did not include in the interdisciplinary team all individuals listed by provision B.7. The revised procedure, which went into effect on January 1, 2011, defines the "interdisciplinary team" as minimally consisting of "a unit manager, Clinician(s), Provider(s), Youth Specialist(s) and staff from Mental Health Services, Psychiatry, Education, Psychology and Recreation. Other participating staff may be included, such as from medical services, religious services, or administration." SOP 404.02.01(III). Further, the procedure states that "[w]henever possible family members will be

included in IDT meetings. Teleconference shall be made available to family members unable to travel to the facility." SOP 404.02.01 (IV.C). We commend the State on its use of telecommunication to further parental involvement in interdisciplinary team meetings.

Our review of IDT team meeting minutes revealed that, there was limited psychiatric involvement in the IDT, most likely due to the limited psychiatric resources at Scioto. Specifically, for IDT meetings from November 11, 2010 to January 13, 2011, there were no psychiatrist attendance signatures. (See Glindmeyer Second Mental Health Report at 14). Youth confirmed the lack of psychiatric involvement in IDT meetings. One youth stated that the psychiatrist "comes to my team sometimes" while other youth noted that the "psychiatrist had not attended their IDT meetings." Id.

Separately, we are troubled by the lack of consistent participation of YS staff in IDT meetings. During one IDT meeting, the YS appeared to be listening to the conversation but was pulled away by duties to answer the phone and respond to other YS staff who approached her. Id. YS staff appeared to be not interested or indifferent to group therapy sessions. For example, a group of male YS staff who were seated in the back of the room were talking and laughing amongst themselves as a female youth was discussing being gang raped. (See Glindmeyer Second Mental Health Report at 17). The YS staff actions were disruptive, counter therapeutic, insensitive and dismissive of the youths' experiences. We reported this issue to Scioto administration immediately. However, they chose to relocate the group therapy session rather than deal with the YS staff issue. Id. We note that mental health staff indicated that this type of disruptive behavior by YS staff was a frequent occurrence. Id. Rather than being a disruption, YS staff should meaningfully participate as "full-fledged" functioning members of the IDT. (See Glindmeyer Second Mental Health Report at 14)

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

As discussed above, the continued lack of psychiatry staff participation in the IDT is troubling. The State should ensure that psychiatrists are sufficiently available to allow their participation in Interdisciplinary Treatment Team meetings. We strongly urge the State to educate all staff regarding the importance of the group therapeutic process and ensure that direct care staff are treated as valued members of the IDT. The State should consider quality assurance monitoring of treatment planning efforts and IDT meetings.

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 policies and procedures and youth records, and interviewed staff. Based on this review, we found that the State is in the process of collating multiple treatment and case planning documents into one overarching document called the Integrated Treatment Plan ("ITP"). The relevant policy, "Behavioral Health Services," describes the ITP document as a formal plan to address youth's various needs (including but not limited to mental health, rehabilitation and psychiatric). Scioto first implemented this policy on January 1, 2011. We are encouraged by the State's progress towards implementing this policy, since it requires the treatment team to consistently document youth progress and information gleaned during treatment team meetings. At the time of our February 2011 tour, mental health staff gave various estimates as to the number of youth whose plans had been re-written to

meet the new policy requirements. The State indicated that it aimed to complete the process for all youth plans by March 1, 2011. (See Glindmeyer Second Mental Health Report at 19).

During treatment team meetings, mental health staff appeared to be interested and knowledgeable about the youth, but the "rich discussion observed in treatment team" did not translate into an intervention and practice regarding the youth. (See Glindmeyer Second Mental Health Report at 15.) For example, at the time of our tour, one particular youth (110) had been in his room for four days and was apparently decompensating. The individualized behavioral plan for this youth provided nothing with regard to reward for positive behaviors that related to the January 15, 2011 goal of having the youth leave his room. While the youth responded to treatment with injections of neuroleptic medication, he began experiencing extra pyramidal side effects (typically tremors, slurred speech, anxiety, paranoia and akathisia). (See Glindmeyer Second Mental Health Report at 15). Rather than address the youth's side effects through medications commonly used to ameliorate side effects, the psychiatrist discontinued the injections, which had kept the youth relatively stable. As a result, the youth decompensated. Youth 110 began refusing oral medications and was reportedly unable to tolerate the stimulating environment of the unit and thus preferred to stay in his room. The facility's lack of psychiatric resources may have contributed to this pharmacological mistake. (See Glindmeyer Second Mental Health Report at 15-16). Had the State provided more resources and attention to Youth 110, the treatment team may have considered alternative modalities.

Although the mental health staff acknowledged that they should have developed alternatives instead of permitting the youth to remain in his room (the youth had begun to refuse to leave, bathe, or take psychotropic medication) the mental health staff struggled with creating a workable treatment intervention as they awaited permission to involuntarily medicate the youth. Ultimately, the

mental health staff created a new individual behavior management plan and the youth was relocated to another unit with limited stimuli. However, the YS staff had no written instructions available to them and reportedly had not received any training regarding the management of this youth's needs. (See Glindmeyer Second Mental Health Report at 16).

The 10 ITPs that the State provided us were of variable quality. The plans had admiral goals for youth, but the goals themselves were not measurable. For example, Youth 888's ITP goals included "reduc[ing] mental health symptoms and their impact on my daily life." (See Glindmeyer Second Mental Health Report at 19-20). Similarly, each goal included objectives, but only some objectives were measurable. Separately, one youth reported that the development of treatment goals was rushed and "tacked on to the end of the meeting." (See Glindmeyer Second Mental Health Report at 14).

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

The State should begin quality assurance monitoring of treatment plan documentation and implementation to ensure compliance with the requirements of this provision. (See Glindmeyer Second Mental Health Report at 20).

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's verbal self-assessment, policies and procedures, documents requested prior to tour, and youth records, and interviewed youth and staff. Consistent with our Second Compliance Report, 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* can independently access a QMHP in a timely manner. Also, consistent with our Second Compliance Report, Dr. Glindmeyer confirmed that access to mental health services continues to be dependent on whether a YS staff member is willing to call and request the service for the youth. Dr. Glindmeyer notes that of the youth she interviewed, "some youth indicated that they had to access mental health services via direct care staff, and 'sometimes they don't like you and don't want to do it.' Another youth reported, 'we don't fill out the request because [psychology staff] is there . . . but if they aren't staff has to call . . . and sometimes they don't want to do it . . . your regular staff usually will, but others could care less.'" (See Glindmeyer Second Mental Health Report at 21-22).

In the State's written self-assessment for our November 2010 compliance tour, the State relied on particular language in the Youth Handbook that 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." In our Second Compliance Report, we stated that, while we recognize that Scioto has readily available "Request for Services" forms, we were nevertheless concerned by the generic and vague description of staff's role in obtaining assistance for the youth. More importantly, we expressed our concern that youth must go through staff in order to access care. (See United States' Addendum to Second Compliance Report at 16). During our February 2011 tour, mental health staff explained that YS staff "verbally instructed" the youth to place the "Request for Services" form in the sick call box. (See Glindmeyer Second Mental Health Report at 22). The State must delineate this process and instruct youth on how to access mental health care without going through staff. Accordingly, the State remains in beginning compliance with this provision.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

The process for youth to self-refer to a QMHP should not rely on staff involvement. The State should revise its handbook to clearly state that youth need not go through staff to seek mental health services and delineate the process that they can follow to self-refer that does not involve YS staff involvement.

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 PowerPoint presentation, verbal self-assessment, relevant policies and procedures, and youth records. On January 1, 2011, the State implemented its "Behavioral Health-Special Services Living Units" policy, which guides the development of the Behavioral Health Review Panel. As we stated in our last report, we encourage the implementation of this policy because it requires that the interdisciplinary review and treatment process begin at the time of the youth's admission. As stated earlier, the Behavioral Health Review Panel has started reviewing intake data for youth who arrive on Tuesday of each week and making recommendations about youth's housing, programming, and treatment needs. Staff indicated that they plan to expand the responsibilities of the Behavioral Health Review Panel to include the review of the reception summaries of all youth admitted to Scioto. We commend the State for moving forward with the requirements of this provision.

The Youth intake screenings and completed intake assessments for the 10 most recently admitted youth indicate that staff recommended that they all go to

general population. (See Glindmeyer Second Mental Health Report at 23-24). In some of these 10 cases, staff recommended additional treatment modalities, including substance abuse treatment. The State should assess whether all of the youth placed in general population belong in the general population. Specifically, the State should track youth who are initially recommended for general population, but ultimately require an increased level of care.[8] Such an assessment will reveal whether the State is adequately capturing all youth in need of mental health services and may prompt changes in the intake assessment process.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

We commend the State for finalizing and implementing the "Behavioral Health-Special Services Living Units" policy and beginning to implement the Behavioral Health Review Panel. The State has moved from beginning compliance to partial compliance with this provision. In order to reach substantial compliance, we encourage the State to monitor and track the efficacy of its policies and institute 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).

[8] This is consistent with Dr. Glindmeyer's recommendations for provisions C.3 ("Identification of Previously Unidentified Youth with Mental Disorders").

In order to assess this provision, we reviewed the State's PowerPoint presentation, verbal self-assessment, relevant policies and procedures, youth records, staff schedules, and interviewed staff. In our Second Compliance report, we determined that staff shortages existed at Scioto that compromised youth's mental health care. We cautioned the State that the associated stress on staff was not sustainable. Unfortunately, in the intervening months since our last assessment, the State has not improved in this area. Instead, Scioto has lost critical mental health staff. Specifically, while in November 2010, Scioto had a total psychiatric physician coverage of .7 Full Time Equivalent ("FTE") – which was insufficient coverage to meet the mental health needs of Scioto youth – Scioto now only has .42 FTE psychiatric coverage. While Scioto had an administrative psychiatrist on staff at the time of our last review, that position is now vacant.

The one psychiatric physician at Scioto only provides a total of 17 hours of clinical services per week. A review of the current psychiatrist's curriculum vitae revealed that he completed a fellowship in child and adolescent psychiatry, and is board certified in adult psychiatry by the American Board of Psychiatry and Neurology. Although the psychiatrist is not board certified in child and adolescent psychiatry, he is board eligible.

According to staff, this psychiatric physician interviewed for a potential full-time position at the facility and received an offer of full-time employment in late February 2011. However, even if the part-time psychiatric provider accepts full-time employment, Scioto does not have adequate psychiatric coverage if this psychiatrist is unavailable for any reason, including vacation, illness, or an unexpected absence. Moreover, the peer review process we have consistently recommended to the State requires at least two psychiatric providers.

Youth expressed variable levels of satisfaction with psychiatric care. Some youth were frustrated and indicated that they had to wait long periods to see the pyschiatrist. For example, staff identified one youth at admission as in need of a

psychiatric evaluation but, due to limited resources, staff did not conduct the evaluation until six weeks later. One youth reported that, while the youth saw the psychiatrist at a reasonable interval, "he is just so busy . . . that he doesn't listen . . . and sometimes I think he blows me off." (See Glindmeyer Second Mental Health Report at 31). Another youth had a more positive report, stating "the doctor comes to my treatment team." Id.

The State provided us with an analysis of its resource requirements. In this February 22, 2011 document, entitled "Rationale for the Distribution of Psychiatry Hours," the State assumed that approximately 50% of the youth committed to DYS will receive mental health services. However, based on the relevant literature, this is an underestimation of the number of youth who need services. (See Glindmeyer Second Mental Health Report at 30). The State further assessed how many youth would require minimum, moderate, or high levels of mental health care. The State ultimately calculated that one FTE of psychiatric coverage would be sufficient to cover the 2496 annual hours of direct and indirect clinical service requirements to meet the needs of Scioto youth. One FTE is not likely sufficient to meet these youths' mental health needs. Id. The State should re-evaluate the need for additional resources at Scioto.

With regard to psychology, the State reported that it has a total of four psychologists and six psychology assistants on staff. According to staff interviews, the facility employs a total of seven psychologists, three of whom are licensed, plus a psychology supervisor and two psychology assistants. Of the seven psychologists, five are assigned to the assessment units and the remainder are assigned to the program units. This level of staffing is consistent with our last review.

During our last assessment, 14 social workers provided services to Scioto youth. While there are still 14 social workers officially on Scioto's staff, staff reported that three social workers were absent from the facility for various reasons, leaving 11 social work staff actually on-site and providing services. As noted in the

Protection From Harm section of this report, the State has acknowledged recent instability in social work staffing. See pages 4-5. At the time of the tour, Scioto also had two full-time mental health nurses and two full-time occupational therapists on staff.

In our Second Compliance report, we determined that the psychiatry, psychology and social work staff were not working together to create integrated treatment for the facility youth. Specifically, 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. Since our last assessment, psychiatry, psychology, and social work staff have increased their efforts to work together to integrate treatment for Scioto youth. As discussed earlier, Scioto is in the process of consolidating treatment planning documentation into one overarching document, the Integrated Treatment Plan. However, during interviews, staff provided inconsistent estimates regarding the number of youth who had actually received an Integrated Treatment Plan.

The State has not 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 as required by this provision.

Finally, we appreciate that the State has made efforts to remedy the staffing problems at Scioto. The State is engaging in active recruitment attempts to fill the administrative psychiatry position, which might allow for sufficient coverage. In the interim, in an effort to provide peer review and coverage, administrative staff is exploring the possibility of a contract with a local hospital. We look forward to assessing the results of the State's efforts in our next compliance report.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

The State cannot reach substantial compliance with this provision until it recruits additional mental health staff and fills the current vacancies. The State must significantly increase its psychiatric coverage in order to meet the mental health needs of Scioto youth. The lack of adequate psychiatric staffing at Scioto has hurt the quality of mental health services, as indicated in several other provisions, including B.7 ("Treatment Teams"), B.12 ("Medication Notice") and B.13 ("Mental Health Medications"). The State should consider re-evaluating its staffing needs based on the technical assistance provided by Dr. Glindmeyer on-site and in her report. On the other hand, we are encouraged by the improved coordinated between psychiatry, psychology and social work staff and the State's initial efforts to implement the Integrated Treatment Plan.

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 PowerPoint presentation, verbal self-assessment, relevant policies and procedures, and youth records, and interviewed youth and staff. During our February 2011 tour, staff acknowledged that the current psychiatric practitioner is not obtaining informed consent for youth who are already receiving prescribed psychotropic medications when they enter the facility. This provision requires the State to document youth's informed consent for treatment with psychotropic medication, whether the youth's prescription is new or a continuation of care from another provider. The psychiatric

provider reported that he does attempt to contact the youth's parent or guardian regarding new medication prescriptions.

In our Second Compliance Report, we determined that the State was in beginning compliance with this provision. Specifically, our review of youth records revealed that documentation regarding risks, benefits, side effects, and alternatives to treatment was present in youth's files but of varying quality. Our more recent review of youths' initial psychiatric evaluations revealed that there is no documentation of informed consent in the files of youth who enter the facility on prescribed medications and no documentation of the appropriate elements of informed consent in the files of youth who are prescribed psychotropic medications post-admission. (See Glindmeyer Second Mental Health Report at 27-28). Given the lack of documentation in youth's files, coupled with the staff's concession that informed consent is not occurring, we must find that the State is non-compliant with this provision.

Scioto staff are aware of the challenges and deficiencies in the area of informed consent for psychotropic medication. During interviews, staff expressed the desire to see more consistency in documentation of informed consent, but also expressed concern regarding the limited psychiatric coverage. (See Glindmeyer Second Mental Health Report at 28). Staff further reported they are in the process of developing information for the youth and their parents on side effects of the psychiatric medications. Id. Interviews with youth revealed that youth are able to name some of the medications prescribed and some side effects of the medications.

Finally, the State has not filed any petitions for authorizations to involuntarily administer medications.

Compliance Rating: Non-compliance

Recommendation(s) to reach substantial compliance:

The State cannot reach substantial compliance with this provision until it consistently documents the presence of informed consent. The State must also document that it notifies youth that they have an opportunity to refuse such medication and that they received informed explanations of the potential consequences of refusing medication. While it is a positive sign that youth continue to be able to name some of the medications prescribed and some of the side effects, the State must document that it is consistently providing youth, and, to the fullest extent practicable and appropriate, his or her parent or caregiver, with information regarding the goals, risks, benefits, and potential side effects of medication. The State has not made any progress in this regard since our last assessment. In fact, likely due to staffing limitations, the State's documentation of informed consent has worsened. In our Second Compliance Report, we encouraged the State to consider a peer review process for informed consent and to develop information regarding side effects of psychotropic medication that is written in language that youth can understand. We continue the urge the State to adopt these recommendations.

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 PowerPoint presentation, verbal self-assessment, relevant policies and procedures, lists of youth

prescribed medication, mental health caseload documentation, 10 youth records, clinical observations, and interviewed youth and staff. Since our last review, the State has updated and approved the "Recommended Laboratory Monitoring Frequency Guidelines." While this policy is adequate, the State should ensure that it reviews this policy annually so that it remains consistent with generally accepted practices. We applaud the State for finalizing this draft policy. However, the State's ability to ensure that psychoactive medications are prescribed, distributed, and monitored properly and safely, and consistent with generally accepted practices, is limited due to the current shortages in psychiatric coverage. Consistent with our last review, the psychiatry clinic at Scioto is not yet fully functional. The psychiatrist is making efforts to perform initial psychiatric evaluations, provide ongoing medication management, and attend some interdisciplinary team meetings. While we commend the psychiatrist's efforts, the State cannot reach substantial compliance with this provision with its current psychiatric coverage.

Documentation regarding the most recent ten youth admitted to the facility who were prescribed psychotropic medication revealed consistent deficiencies. Youth psychiatric records lacked critical information, including weight and vital signs, monitoring for abnormal involuntary movements, information regarding laboratory examinations, the basis for the psychiatrist's diagnosis (the "diagnostic formulation"), or the youth's symptoms that formed the basis for prescribing the medication(s). (See Glindmeyer Second Mental Health Report at 31-33).

However, youth psychiatric records include adequate documentation of the youth's historical information. In addition, most youth we interviewed were knowledgeable about most of their prescribed medications and were able to articulate the symptoms that some of the medications are addressing and some basic side effects. Youth also indicated that laboratory examinations had been performed during their stay at Scioto. Other positive aspects of psychiatric care

that we identified during our last review remain in place. For example, the psychiatrist again reported good access to laboratory examinations and reported taking after-hours calls for psychiatric emergencies at the facility. Also consistent with our last review, the psychiatrist did a good job establishing rapport with the youth during clinics, queried the youth regarding signs and symptoms of mental illness, inclusive of historical data, and reviewed the youth's medical record, inclusive of school and behavioral information.

At the time of the February 2011 tour, there were 138 youth housed on campus. Of these, 33 (or 24%) were prescribed psychotropic medication. Of these 33 youth, 9 were prescribed stimulant medications associated with diagnoses including Attention Deficit Disorder ("ADD"), Attention Deficit Hyperactivity Disorder ("ADHD"), or other Axis 1 mental health disorders.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

In order to reach substantial compliance with this provision, the State must recruit psychiatrists to fill the available positions. As youths' psychiatric records demonstrate, the State cannot ensure and document that psychoactive medications are prescribed, distributed, and monitored properly and safely without sufficient mental health staffing. Specifically, the documentation deficiencies we discovered are likely the result of diminished clinical resources. We continue to recommend that the State improve psychiatric documentation through quality assurance monitoring or a peer review process. In addition, the State should ensure that it provides 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, as required by this provision.

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 PowerPoint presentation, verbal self-assessment and training documents. The State has provided an update on the behavioral health policy and procedure for all staff, trauma training for staff assigned to the girls units and the boys mental health unit, and training regarding self injurious behavior for staff assigned to the girls units and the boys mental health unit. The State also provided a three-day mental health intensive training to assist staff with the treatment team process. However, mental health staff excluded direct care staff from this training. Direct care staff would have benefited from this information. Direct care staff are an important part of the youth's treatment team.

The State's failure to include direct care staff in treatment team training is indicative of a larger problem at Scioto. It is apparent that direct care staff do not consider themselves to be an integral part of the treatment program. (See B.7 ("Treatment Teams")). Dr. Glindmeyer provided the State with technical assistance on this matter during and after the tour. This is an area that will require a cultural shift at the facility, and will require teamwork, integration, and training.

Despite our request for a spreadsheet indicating all trainings attended by Scioto staff and dates of completion, the State failed to provide this information. During interviews, staff conceded that they have "not had the time to address the requirements of provision 14 or 15 thoroughly." (See Glindmeyer Second Mental Health Report at 34). At this time, we have insufficient evidence to determine that the State has made significant improvements with regard to this provision.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

We urge the State to fully integrate direct care staff into youths' treatment teams. We continue to recommend that the State appraise 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. 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 PowerPoint presentation, verbal self-assessment, and training documentation. As noted in provision B.14, Scioto staff frankly acknowledged that they have not had time to thoroughly address the requirements of this provision. The documentation provided by the State to demonstrate compliance with this provision supports the staff's statements. In our document request, we asked the State to provide a spreadsheet indicating which staff had completed training programs relevant to this provision with completion dates. In response, the State provided a list of 11 employees,

presumably all mental health staff, who had attended trainings on youth advocate training, MYR policy review, MYR practice, and mechanical restraints. In the future, the State should provide data regarding training in the required mental health subject matter areas delineated in this provision. This data must include not only training for mental health staff, but training for "all staff who directly interact with youth," including direct care staff and teachers.

The State reported that it has trained staff on the new cognitive behavioral and trauma based treatment programs; however, the State did not include documentation of these trainings in the records provided for our review. The State provided numerous other training modules, including "Suicide Precautionary Equipment and Restraints," and "Treatment of Youth with Mental Health Disorders."[9] However, we have no means of assessing staff attendance and training completion. Staff indicated that they have plans to develop a curriculum, a schedule, and a quarterly training regarding specific mental health issues in the future. (See Glindmeyer Second Mental Health Report at 36).

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

We urge the State to provide adequate evidence of its compliance with the requirements of this provision in the future, including a spreadsheet that delineates staff attendance and completion of the required training modules. We recommend that the State track and provide us with information that is directly relevant to its implementation of the requirements of the provision. As stated in the previous provision, the State should 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 caseload.

[9] A complete list is available in Dr. Glindmeyer's report. (See Glindmeyer Second Mental Health Report at 37).

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 PowerPoint presentation, verbal self-assessment, draft policies and procedures, quality assurance documents, and lists of youth on suicide precautions, and interviewed staff. The State provided its policy entitled "Suicide Prevention and Response." However, it appears that this policy is still pending. Mental health staff reported that, on a weekly basis, they review the list of youth on precautionary status and monitor youth on suicide status. Between January 11, 2010 and February 11, 2010, there were 36 instances in which staff placed youth on precautionary status. Of these 36 instances, four youth required precautions a total of two times, two youth required precautions a total of three times, and one youth required precautions a total of four times. Accordingly, six youth accounted for 16 instances of placement on precautionary status. These data indicate that a subset of youth may require additional mental health intervention and suicide precautions.

In our Second Compliance Report, we requested that the State provide quality assurance measures regarding suicide prevention. The State provided an example of an audit tool and an example of a compliance summary regarding suicide prevention. We appreciate the State's response to our request. However, these documents are of limited utility. Both documents were undated, so we could not determine when the State conducted the audit or the compliance summary. In addition, it was difficult to determine the sample size reviewed in the reports. Specifically, while the forms for the audit tool indicated that the sample size should be "10% of youth population and/or no less than 10 samples," the documents also indicated that "all CBT youth and females MH records" were audited, but did not specify a total number of records reviewed. The State's quality assurance measures

indicated 100% compliance across five areas related to suicide prevention. Yet, the compliance summary stated that the sample size was only three youth.

Staff noted anecdotally that the number of youth requiring precautionary status had decreased in the weeks prior to the tour. However, a decrease in the number of youth identified as at risk of committing suicide is likely multi-factorial. Specifically, while the decrease may be the result of improved treatment and intervention or, as Scioto staff hypothesized, the result of youth housed on mental health units settling into the facility milieu, the State must ensure that the reduction is not the result of the State's failure to identify youth at risk of self-injury.

Finally, in our Second Compliance Report, we alerted the State that its failure to develop a formal process for informing the psychiatrist when a youth is placed on suicide watch or other restriction fell below generally accepted standards of care. The State has not addressed this problem, and a formal process is still not in place.

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

In our Second Compliance Report, we determined that the State had not provided us with sufficient information to assess this provision. Accordingly, we determined that the State was non-compliant. We appreciate that the State has provided data regarding the number of youth on suicide precautions and has made efforts towards developing quality assurance measures. We encourage the State to continue its quality assurance efforts and ensure that assessments include a representative sample of all youth and that results are dated. In addition, the State must ensure that it adequately identified and monitors youth requiring precautionary status. We urge the State to consider the need for additional mental health interventions for the subset of youth requiring frequent precautionary

status. We reiterate our concern that Scioto does not have a formal process in place to alert the psychiatrist if a youth in his care is placed on suicide watch. Finally, it does not appear that the State has finalized its suicide prevention policy since our last review. The State cannot reach substantial compliance with this provision until it finalizes and implements its suicide prevention policies and procedures.

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 PowerPoint presentation, verbal self-assessment, ten medical release summaries and psychological service summaries, one discharge plan, and interviewed staff. During our February 2011 tour, staff acknowledged that Scioto is "in the infancy stages of transition planning." (See Glindmeyer Second Mental Health Report at 41). Staff expressed plans to work with social services staff to develop discharge plans and to begin planning youth's discharge upon their admission to the facility.

Our review of recent medical release summaries revealed some improvement in the State's documentation of transition planning, but many of the deficiencies we identified during our last review persist.[10] For example, the medical release summary of Youth 111 included a listing of psychotropic medication, documentation of a 30-day supply of medication, and a listing of diagnoses. However, the youth's psychiatric diagnoses still included two "rule out" diagnoses at discharge, signaling that mental health staff had not finalized this youth's diagnostic assessment despite his two years of incarceration at Scioto. In addition, mental health staff documented concerns regarding this youth's mental health status and history of significant mental health symptoms, yet failed to document concrete mental health

[10] Some of the medical release summaries the State provided were dated prior to our November 2010 tour, so we did not include those forms in the instant assessment.

referrals or linkages to community supports. Youth 222's medical release summary listed diagnoses and medications, but did not specify the amount of the medication the youth was prescribed at discharge. While mental health staff recommended community services, staff did not document how the youth would link with these community services or with whom or where her community psychiatric appointment would occur.

Since our last review, the State has finalized the "Behavioral Health Services" policy. This policy, if appropriately implemented, will help the State meet the requirements of this provision. The subsection on "Discharge Planning" requires the development of a staffing team responsible for creating youth's discharge summary. We reviewed one such discharge summary, dated January 12, 2011, regarding Youth 333. The diagnoses listed on the discharge summary differed from the diagnoses listed on the youth's medical release summary. In addition, two critical pieces of information on the discharge summary were incomplete – the "continuity of care/referral information" and "after care options."

Compliance Rating: Beginning compliance

Recommendation(s) to reach substantial compliance:

We continue to urge the State to develop transition planning services, including concrete linkages with community resources for all youth. Given the staff's verbal self-assessment, it is clear that the State is aware that it has significant work to do to reach substantial compliance with this provision. We encourage the State to proceed with its plans to begin discharge planning at the time of admission. The State should also ensure that staff complete all sections of the discharge summary form. We further recommend that the State begin quality assurance monitoring regarding the quality of documentation of discharge information and the integration of this information with the medical release summary.

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 PowerPoint presentation, verbal self-assessment, quality assurance reviews, and interviewed staff. At the time of our last review, the State's policies and procedures regarding Quality Assurance and Clinical Supervision were still in draft form. Staff reported that these policies and procedures became effective January 1, 2011. This policy does not clearly outline how the State should document its quality assurance reviews. While this policy may be purposefully vague, the State should consider reevaluating and clarifying the policy if the documentation deficiencies we identify below persist.

The State provided quality assurance reviews regarding "Integrated Treatment and Service Delivery." The reviews were not dated, so we cannot determine the dates or time periods of review. The documents listed multiple headings of subject matter reviews, including Individual Treatment Planning and Mental Health Referrals and Services.[11] The documents list standards below each of these headings. However, the documents do not define what the standards are, nor did the State provide a copy of the guiding document defining the standards. Accordingly, we could not assess the State's compliance with specific areas.

Despite these deficiencies, the Integrated Treatment and Service Delivery review was informative. Facility reviewers assigned numerous areas compliance ratings of 70% or below. For example, reviewers assessed seven items related to Individual Treatment Planning. Of these seven items, reviewers rated one at 100%,

[11] A complete list is available in Dr. Glindmeyer's report. (See Glindmeyer Second Mental Health Report at 44).

but reviewers rated the remaining six at below 68%. Of those six below 68%, reviewers rated two items at 0% and two items at 12%. Overall, the average rating for Individual Treatment Planning was 35.4%. Dr. Glindmeyer provides a thorough assessment of the results of the State's analysis in her report. (See Glindmeyer Second Mental Health Report at 45).

The State also provided a December 15, 2010, performance review for one mental health provider and the social services weekly report. The State did not provide documentation regarding regular clinical supervision of providers. The social services weekly report demonstrated that a small subset of Scioto's treatment staff exhibit a lack of commitment to the overall mental health treatment program. For instance, some staff missed multiple group therapy sessions. According to the weekly report for the week ending January 10, 2011, one provider did not have any documentation of individual sessions with youth documented in the case notes for the previous month. According to the report for the week ending December 20, 2010, treatment staff did not conduct any individual sessions regarding Youth 111 for the previous week. This finding is problematic, given Youth 111's serious mental health issues, which, as stated above, led the treatment team to place him in isolation without time out of his room for a period of four days.

As required by the newly implemented policies, the first quality improvement meeting took place on February 8, 2011. The State did not provide the minutes of this meeting, so we cannot yet assess the efficacy of this aspect of the policy's implementation.

During our February 2011 tour, staff reported that they are keeping statistics, but do not have a system in place to manage and analyze data. Staff also indicated that they have created a database for quality assurance information, and have hired a data manager. We recognize that the State is in the early stages of developing and implementing the framework for its new mental health care system.

However, since our last review, the State has made notable progress by developing mechanisms to track data and hiring a data manager.

Compliance Rating: Partial compliance

Recommendation(s) to reach substantial compliance:

In order to reach substantial compliance with this provision, the State should complete staff training and implement the planned mental health administrative structure, meetings and treatment modalities. Following the full implementation of these programs, the State should renew its efforts to engage in quality assurance monitoring to assess the efficacy of staffing, treatment and interventions. Finally, when providing quality assessment results, the State should ensure that it dates the documents and describes the standards it is monitoring.

III. GENERAL MEDICAL CARE

Juveniles in the custody of state correctional facilities have a due process right to adequate medical care. In order to assess the General Medical Care provisions, we reviewed relevant policies and procedures, staffing schedules, statistical data regarding completed dental procedures, staff training curricula, the health records of 12 youth, and interviewed youth during our February 2011 tour. We have attached the findings of our subject matter expert, Dr. Michelle Staples-Horne, to this Compliance Report. (See Staples-Horne Second Medical Report at Attachment D).

C.1 GENERALLY

> *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.*

We are pleased to report that the State continues to provide quality medical care to the youth at Scioto. Youth receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards and youth with health problems are identified, assessed, diagnosed, and treated consistent with current, generally accepted professional standards of care. Moreover, the ODYS medical policies and procedures continue to meet the American Correctional Association ("ACA") and the National Commission on Correctional Health Care ("NCCHC") standards for providing health care to youth housed in juvenile facilities.

According to staffing schedules, Scioto has two primary care physicians – one serves the male population and one serves the female population. The two primary care physicians provide coverage each day of the week, except Wednesday and Sunday, for a combined total of approximately 1 Full Time Equivalent ("FTE"). Consistent with our last assessment, the physicians are Pediatrics and Family Medicine Board Certified to provide primary care and OB/GYN Board Certified to provide services to female youth. While Scioto had two contract psychiatrists at the time of our last review, Scioto now only has one contract psychiatrist. See page 35.

Scioto has two obstetrics/gynecology Medical Doctors ("MD"), two obstetrics/gynecology Doctors of Osteopathy ("DO"), and one certified midwife. These five rotating staff provide obstetrics/gynecology services three hours a week. Scioto has one health information technician/phlebotomist, one dentist, one dental assistant, one dental hygienist, and one optometrist. The optometrist sees youth the second and third Friday of each month. We address dental staffing in more detail in section C.7 ("Dental Care"). Scioto's nursing staff has remained stable since our last review. Eleven Registered Nurses ("RN") and one Licensed Nurse Practitioner ("LPN") staff the clinic, and one RN and one LPN serve the reception area. Scioto also has a Health Services Administrator, who is also a RN, and an administrative assistant. This staffing pattern can provide coverage with at least

three registered nurses on the first and second shifts and two nurses on the third shift, seven days a week, without including the Health Services Administrator in any direct patient care responsibilities.

Based on the average length of stay, the average daily population, the staffing schedules the State provided, and evidence of care documented in the youth medical records, the medical staffing at Scioto continues to be appropriate and adequate. Moreover, the medical staff possesses the qualifications necessary to provide the appropriate level of medical care.

Youth health records continue to demonstrate that the State is generally providing youth with adequate routine, preventative and emergency care. Consistent with our last review, youth health records reflect routine care through a thorough and consistent intake screening process, which includes initial medical, dental, and mental health assessments. While some youth reported delayed access to sick call, our review of health records indicates that medical staff are appropriately addressing and documenting youth's medical complaints. The State's sick call process is discussed more fully in section C.5 ("Access to Health Services").

Medical staff assess youth with injuries in a timely manner. One health record included documentation of adequate emergency care. Medical staff monitor and address chronic diseases appropriately and according to accepted practices. Youth continue to receive appropriate diagnostic services, preventative services, and health education. The State continues to provide comprehensive health services specific to females, including complete gynecological examinations, pelvic examinations, and family planning and pregnancy-related services.

In our Second Compliance Report, we determined that the State could not reach substantial compliance with C.1 until it reached substantial compliance with provision C.7 ("Dental Care"). As discussed in C.7, the State has provided improved documentation of its dental care practices, and is now in substantial compliance

with the Dental Care provision. Accordingly, the State is now in substantial compliance with C.1. We applaud the State's progress in this area.

Compliance Rating: Substantial Compliance

In our Second Compliance Report, we suggested that the State provide regular training to all health care staff to ensure that they are aware of the current accepted professional standards of care. The NCCHC standard Y-C-03 recommends that health care staff attend in-service programs or conferences focusing on topics related to correctional health care. The State submitted training records for 14 nurses and one phlebotomist. The training primarily consisted of courses relevant to the general correctional staff. Examples include Managing Youth Resistance, Information Technology, Cultural Competency and Planned Intervention. The State did not submit any evidence of continuing education designed for health care professionals. We continue to encourage the State to provide health care staff with continuing education, presentations and trainings on the special health needs of adolescents.

Finally, in our last report, we recommended that the State implement an adequate Continuous Quality Improvement ("CQI") process. The State reported that its quality assurance policy is awaiting final approval. Although a CQI component is not expressly included in the Consent Order's requirements, we note that it is an essential part of any medical program that aims to provide quality care. We encourage the State to finalize and implement its CQI policy. Such a policy will help the State maintain its medical program in substantial compliance with this provision.

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.

In order to assess this provision, we reviewed the relevant policies and procedures, and the health records of 12 youth. The State's policies, procedures and practices related to the transfer of records to and from other facilities and institutions continue to demonstrate a commitment to continuity of care for Scioto's youth. The policies and procedures delineate the required components of each health record and explain the records transfer process. The State's practice continues to be consistent with its policies and procedures. Specifically, youth health records are arranged according to the policy and the records contain documentation consistent with the records transfer process, information from outside consultations, and discharge summaries.

In our last report, we recommended that the State include all mental health diagnoses on the problem list. The State has improved this practice and now routinely includes mental health diagnoses on the problem list. We did review one health record where the State failed to include a major medical diagnosis on the problem list. However, we do not believe this one failure is a reflection of the State's practice as a whole.

Despite the State's compliance with certain aspects of this provision, the State has not adopted our recommendation to combine medical and psychology records. While health records include psychiatric evaluations and chronological psychiatric progress notes, records still do not include psychological records, such as case notes. Some progress notes in health records indicate that youth are participating in groups, but the progress notes provide no other details. Accordingly, the State has not yet developed and implemented policies, procedures, and practices to ensure that all health care staff at the facility have access to documents relevant to the care and treatment of the youth.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

In order to reach substantial compliance with this provision, the State must continue moving towards a system that will combine all health records, including psychology records. We recognize that the Consent Order does not mandate an electronic recordkeeping system. However, such a system would improve Scioto's ability to access critical health information by giving health record access to medical, dental, and mental health staff simultaneously. The State reports that it has collaborated with Ohio State University to explore using the "EPIC" electronic health record program that is currently used by the Ohio Department of Rehabilitation and Corrections. We commend the State for taking steps towards the adoption of an electronic system. In addition, we renew our offer to make Dr. Staples-Horne available to provide technical assistance.

C.3 CONFIDENTIAL HEALTH CARE

> *The Facilities shall provide health care and assessment in a setting that maintains health care confidentiality, by placing non-medical staff out of line of sight and hearing of the health care assessment or treatment, except in circumstances where documented safety considerations posed by a particular youth require enhanced, non-medical supervision.*

In order to assess this provision, we reviewed the relevant policy and interviewed youth. Youth continue to report that all visits with medical staff are conducted confidentially. Specifically, youth reported that correctional staff is not within earshot during health care treatment and assessment. If youth are receiving an examination that requires them to undress, the door to the exam room is closed and non-medical staff are out of the line of sight.

Compliance Rating: Substantial Compliance

While the State's practice conforms to the requirements of this provision, the current policy only requires the State to maintain an examination room that allows for the private examination of youth at the medical clinic. It does not provide any specific guidance regarding the conduct of non-medical staff. In our Second Compliance Report, we urged the State to amend Policy #403.04 to reflect the State's actual practice and provide additional guidance to medical and non-medical staff. The State has not modified Policy #403.04. While not expressly required by this provision, we again encourage the State to amend its policy to provide additional guidance to Scioto staff.

C.4 INITIAL HEALTH ASSESSMENT

> *The Facilities shall ensure that initial health assessments are complete and include: use of growth and weight charts; laboratory test results placed in the youth's health records before the youth is transferred out of reception; results of all laboratory tests, to be provided for each test within 20 days of its performance; testing of all youth for sexually transmitted diseases; and a problem list and a plan of care for each problem identified at reception.*

In order to assess this provision, we reviewed the relevant policies and procedures and the health records of 12 youth. Medical staff completed initial health assessments in 100% of the youth health records reviewed. These assessments included the nurse intake screening/assessment, a physical exam, screening for tuberculosis, and gathering information related to mental health and substance abuse concerns. Registered Nurses continue to complete the intake assessments on the day of intake and the Primary Care Physician typically completes physical examinations within one week of admission. All of the records we reviewed included growth and weight charts. Laboratory tests are completed on all youth at intake and test results were returned well within the 20 days required by the provision. When applicable, medical staff conducted gynecological exams in a timely manner. In all of the health records we reviewed, youth were tested for sexually transmitted diseases ("STDs") at intake and received vision and hearing screenings.

Compliance Rating: Substantial Compliance

In our Second Compliance Report, we urged the State to consider amending its policy controlling medical services related to STDs and pregnancy. Specifically, the policy does not authorize minors to release STD and pregnancy-related information to parents or others although minors are legally authorized to release such information. We also recommended that the State amend Policy #403.11 "Health Care Physical Examination-Intake" to reflect the facility's practice of conducting hearing and vision screenings. The State has not amended these policies since our last review. We recognize that these changes are not required by this provision. However, we continue to recommend these changes as technical assistance.

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.

In order to assess this provision, we reviewed the relevant policies and procedures, the health records of 12 youth, and interviewed youth. Scioto's policy and procedures remain the same since our last assessment. Our review of health records indicated that medical staff documented many more assessments of youth in the progress notes than there were sick call forms. Of the 12 health records we reviewed, two did not contain any sick call request forms and one record had only one handwritten request. Either youth are approaching nurses directly with medical complaints instead of completing a sick call form or medical staff are not placing the sick call request forms in the health record. For example, a progress note documented a case where a youth complained of a toe injury while the nurse was on the unit. The RN on the unit evaluated the youth and the youth received further care in the clinic later that day and the following day.

Dr. Staples-Horne's review or health records indicated that, when appropriate, nursing staff refer youth to the physician. The physicians saw youth

and documented these visits in all of the records she reviewed. In one case, the physician completed a minor surgical procedure to incise and drain a boil. One youth complained of ear pain one day and the nurse saw the youth the next day, gave the youth Tylenol and referred the youth to the physician. The following day, the physician diagnosed and treated the youth.

While the dates on the sick call request forms Dr. Staples-Horne reviewed indicated that medical staff see youth in timely manner – usually the following day, numerous youth reported that they experienced delays with the sick call system. Specifically, youth alleged that they had waited three or more days to have a sick call request filled. Other youth alleged that their sick call requests went ignored. For example, one youth alleged that after playing in the gym, she suffered toe pain and submitted two sick call requests that were not answered. She then verbally asked three times to go to the medical unit and was not sent. Finally, two weeks after the youth filed the original sick call request, a nurse saw the youth, performed x-rays, and determined that the youth had a fractured toe. The youth was given pain medication, but should never have been forced to walk on a fractured toe for weeks. We notified the State of these concerns in a March 11, 2011 letter.

In our Second Compliance Report, we determined that the State had reached substantial compliance with this provision. However, we are concerned that youth reported experiencing significant delays when seeking medical care through the sick call system. We strongly urge the State to implement quality assurance mechanisms to address youth's concerns expressed during our February 2011 tour.

Compliance Rating: Partial Compliance

The State must ensure that youth have unimpeded access to medical care. As stated above, we encourage the State to implement quality assurance measures. In addition, in our last compliance report, we made several recommendations that would improve youth's access to health care services at Scioto. We recommended

that the State change its sick call Standing Order #403.07 from "Standing Order" to "Nursing Protocols" in accordance with the NCCHC's Standard Y-E-11. We further recommended that the State ensure that sick call health assessments are completed by RNs and not LPNs and specify this change in its policies. The State has not implemented these changes. We continue to urge the State to implement these changes to ensure that youth have unfettered access to quality care. Finally, we recommended that the State review its policies and procedures at least annually, and update them as needed. While the State updated its sick call procedures in March of 2010, the State had not reviewed these procedures for the previous three or four years. We encourage the State to consider reviewing this procedure soon since more than a year has elapsed since the State's last review.

C.6 MEDICATION MANAGEMENT

The Facilities shall not discontinue a chronically ill youth's usual medication for non-medical reasons, including that the medication is not on the Facilities' formulary.

In order to assess this provision, we reviewed relevant policies and the health records of 12 youth. Based on our review, it appears that Scioto continues to provide medication to chronically ill youth in its custody. The prescriber's orders for medications and medication administration records continue to be complete and present in all youth health records. Nurses are administering and documenting medications as ordered. Progress notes adequately document treatment refusals made by youth. Scioto continues to document hot weather precautions for youth who are taking medications that predispose them to heat sensitivity and Abnormal Involuntary Movement Scale ("AIMS") for youth on psychotropic medications.

In our last assessment, we recommended that the State modify its current policy to reflect Scioto's practice for securing medications not listed on the formulary. Specifically, if a particular medication is not available on the formulary, Scioto obtains the medication from a local pharmacy. The State has not yet modified its current policy. While we believe this practice is beneficial and should

be documented in the State's policy, we recognize that the State has met the requirements of this provision.

Compliance Rating: Substantial Compliance

C.7 DENTAL CARE

The Facilities shall ensure that:

a. *Dental restorative needs are listed on a dental treatment plan for the youth, tracked by the dental program, and treated on a timely basis consistent with generally accepted professional standards of care;*
b. *Prosthetic dental services are provided based on need, as determined by the treating dentist, with appropriate consideration for the replacement or repair of missing front teeth, according to generally accepted professional standards of care;*
c. *Youth experiencing dental pain are not denied adequate pain medication;*
d. *Health records contain adequate documentation of all outside dental consults, including the clinical examination, treatment plan, procedures performed, orders for management after the procedures, and any follow-up appointment or plan; and*
e. *Dental staffing is adequate to meet the restorative dental needs of the Facilities' populations.*

In order to assess this provision, we reviewed the relevant policies and procedures, data provided by the State, and the dental records of 12 youth. In our Second Compliance report we determined that the State had not reached substantial compliance because the State's dental record-keeping was inadequate and did not consistently include documentation of dental examinations and treatment. We also expressed our concern that the follow up dates for restorative procedures – specifically, fillings – may be set too far out in the future to ensure completion prior to youth's release. Finally, we could not determine whether dental staffing was adequate to meet the restorative dental needs of the Facility's population.

The State has now provided adequate information to support a determination that it has reached substantial compliance with this provision. The State provided

statistical data for dental services completed and dental staffing schedules. The dental hygienist works up to 16 hours per week and averages one to two dental prophylaxes per hour. The dentist and dental assistant work up to 30 hours per week and complete an average of 97 examinations and 34 restorations per month. Dental staffing appears to be adequate. However, our review revealed that there was a downward trend in the number of youth dental staff examined between September and December 2010 compared to the previous months of 2010. We do not have data to determine the cause of this shift and whether the trend has continued into 2011.

Our review of health records revealed that each youth received three to four dental x-rays each. Appropriately, dental staff conducted far more restorations than extractions. Dental staff documented that they provided youth with sealants and dental appliances (night guards) and made appropriate referrals. Scioto's provision of night guards is an example of prosthetic dental services. Youth experiencing dental pain were seen by the nurse and given pain medication until seen by the dentist, usually the following day. One youth submitted more than one sick call request complaining of dental pain. However, the nurse documented in the progress note that the youth had admitted that she had seen the dentist, but refused to get fillings because she was afraid of needles.

Based on the data submitted by the State, the State has reached substantial compliance with this provision. We applaud the State for providing quality dental care to Scioto youth.

Compliance Rating: Substantial Compliance

While the State has reached substantial compliance with this provision, we encourage the State to continue to track the number of youth examined by dental staff and to investigate potential causes of the downward trend that began to occur between September and December 2010.

C.8 MANAGEMENT OF CHRONIC ILLNESSES

The Facilities shall ensure that:

a. *Chronic disease policies, protocols, and practices are appropriate for chronically ill adolescents;*
b. *Youth with chronic asthma are continued on their established medicines on admission unless the youth's condition warrants a change in treatment; and*
c. *Youth who frequently use rescue inhalers are appropriately monitored and treated by physicians to minimize preventable asthma hospitalization resulting from acute respiratory crisis that follows an inadequately treated exacerbation of chronic asthma.*

In order to assess this provision, we reviewed the relevant policies and procedures and the health records of 12 youth. The youth whose records we reviewed have the following chronic illnesses: hypertension, seizure disorder, hypothyroidism, renal disease, asthma, hepatitis C, latent tuberculosis, and a cardiac condition. We also reviewed the health records of two pregnant females. The State continues to provide quality medical care to youth with chronic illnesses. One pregnant youth's care was particularly challenging due to her additional diagnoses of hypertension, renal disease, and asthma. Scioto provided prenatal care consistent with the accepted standard of care. Medical staff provided a youth with hepatitis C with extensive education regarding her disease, liver ultrasound studies, appropriate laboratory tests, and immunizations.

Of the files we reviewed, four youth's records indicated a history of asthma. Three of these youth have mild asthma. One of these three youth did experience an exercise induced asthma attack, and medical staff appropriately changed this youth's medication order to allow the youth to use the inhaler prior to exercise. The fourth youth had severe persistent asthma, required multiple medications and had a history of numerous hospitalizations. Medical staff managed the care of this youth well and provided the youth with routine visits to an outside allergist for Xolair medication injections.

The State provides excellent continuity of care for youth with chronic diseases. Medical staff include medical records from community providers in youth's health records as well as care plans when youth are nearing release back into the community. The State remains in substantial compliance with this provision.

Compliance Rating: Substantial Compliance

C.9 ACCESS TO SPECIALTY CARE

Absent clinically justified rationale, the Facilities shall not withhold access to specialist services recommended by a treating physician and shall ensure that: prior approval of specialty medical consultations is made by a physician trained and qualified in pediatrics and adolescent medicine; and assessment criteria for the necessity of specialty consultations are based on pediatric and adolescent medicine.

In order to assess this provision, we reviewed the relevant policies and procedures and the health records of 12 youth. Scioto continues to provide youth with adequate access to specialty care. The facility physician is trained and certified in pediatrics and adolescent medicine and appropriately referred youth to outside consultations with Nephrology, Cardiology, Neurology and Obstetrics specialists. Youth received optometry care and the State routinely purchased glasses when youth failed the vision screening. The State provided other diagnostic studies, including x-rays, ultrasounds, and EKGs where appropriate. Pregnant females received appropriate prenatal care as documented by the completion of the American College of Obstetrics and Gynecology ("ACOG") recommendations for ante partum care.

Compliance Rating: Substantial Compliance

C.10 IMMUNIZATIONS

The State shall make reasonable efforts to obtain immunization records for all youth who are detained at the facilities for more than one (1) month. The State shall ensure that medical staff update immunizations for such youth in

accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a youth is medically inappropriate shall properly record such determination in the youth's medical record.

In order to assess this provision, we reviewed the relevant policy and procedure and the health records of 12 youth. Consistent with our last review, youth continue to receive appropriate immunizations in accordance with the Center for Disease Control and Prevention's and the Advisory Committee on Immunization Practices' recommendations, including HPV and influenza vaccines. Eleven of the 12 health records we reviewed included immunization records. Of the 11 youth files with health records, one youth was not brought current on her immunizations while at Scioto, but her immunization records from a previous facility or school were present in her health record. The one youth who had no immunization records in her health record had recently entered the facility. Scioto continues to update immunizations for youth who are detained for more than one month. The State continues to be in substantial compliance with this provision.

Compliance Rating: Substantial Compliance

We continue to urge the State to update the relevant immunization policy and procedure. The State's policy and standard operating procedure were last revised January 3, 2006. Accordingly, they do not reflect the current practice of providing all recommended vaccinations.

IV. GRIEVANCES

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. (See Consent Order III.D.1)

In order to assess this provision, we reviewed the State's self-assessment, documents requested prior to tour, 106 grievances submitted between November 1, 2010 to February 1, 2011, and interviewed youth. In her report, Dr. Dedel notes that all grievances reviewed during the relevant time period were handled in a timely manner, youth received notification, and that the CIO requested additional follow up regarding 15% of the grievances. (See Dedel Third PFH Report at 16). Further, consistent with language in the provision, the policy has no preconditions for filing a grievance, youth receive notification of the grievance resolutions, grievances are picked up each weekday, and all grievances are reviewed by the Chief Inspector's Office.

Based on our February 2011 interviews with youth[12], we are concerned, however, that there is a *de facto* precondition or limitation to completing and submitting grievances alleging staff mistreatment. The *de facto* precondition exists for two reasons: (1) some YS staff routinely inform youth[13] that Scioto prohibits youth from grieving any action by staff and (2) Scioto's explanation to youth about grievances is incomplete or inadequate (discussed in D.2 below.) Combined, the intentional misinformation by some YS staff and the incomplete explanation about how the facility handles grievances (including staff mistreatment) create a perception to youth that the grievances about staff mistreatment are not accepted

[12] During our February 22-24, 2011, 19 of the 25 youth interviewed voiced a deep mistrust of the grievance system. Youth alleged that YS staff told them that Scioto prohibits youth from grieving about staff mistreatment, or grieving the consequences and punishments received from staff. The number and consistency of these allegations are problematic, and place Scioto at odds with even its own Youth Handbook (discussed below in F.2), which only prohibits youth from filing a grievance against the sentence they received from the Court. Due to this confusion and inconsistency, through a letter dated March 11, 2011, the United States suggested the State provide a "refresher training" for all youth and staff about the grievance system.

[13] Some youth interviewed alleged that some YS staff tell youth that they (the youth) can "file a grievance, but nothing will happen," in effect stating that the facility will ignore the grievance.

or investigated. Further compounding the perception is that when a youth does file a grievance against a staff member, the facility's procedures re-route such grievances from the grievance officer to the CIO. Independently, the re-routing of such serious grievances to CIO is not the issue. Instead, the problem lies in that youth receive no update from the grievance officer, the one individual who youth know handles grievances, or the CIO about the grievance. In other words, while the CIO may be diligently investigating the mistreatment grievance, the youth do not know this and never receive a notification about the resolution. This reinforces the youth's perception that the facility does not permit or handle grievances against staff.

Compliance Rating: Partial Compliance

Recommendations for reaching Substantial Compliance:

The State must clarify its education of youth about the grievance process, rules, procedures, and roles of individuals. To implement such change, the State should revise its youth handbook and orientation presentation to youth to unequivocally explain to them how: (1) grievances are accepted, (2) handled, (3) processed, and (4) investigated. Further, youth should be able to discern from the handbook what their rights are regarding grievances (notification and time frames). In particular, youth must be educated about how a complaint/grievance/allegation about any staff mistreatment will be treated by Scioto and the CIO's office and that, despite a youth's unwillingness to cooperate, the investigation about staff mistreatment will proceed.

Separately, all staff should be advised about: (1) the consequences for intentionally misinforming youth about their rights, especially grievances, (2) the consequences for observing and failing to report staff mistreatment, (3) how staff mistreatment grievances will be handled, and (4) how youth will be informed about the investigation of a grievance that involves staff mistreatment.

D.2 GRIEVANCE 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.* (See Consent Order III.D.2)

In our assessment of this provision, we reviewed the State's self-assessment, the relevant policy, the revised October 2010 Youth Handbook, and interviewed youth. The relevant ODYS policy requires that, upon admission to Scioto, staff shall provide youth with a copy of the Youth Handbook, instruct the youth on the grievance system, and ensure the youth sign a letter of understanding regarding the process. All but one youth interviewed reported having received a copy of the Handbook and all could describe the mechanics of the youth grievance process. Dr. Dedel notes in her report that the Scioto audit for youth admitted from November 1, 2010 to January 31, 2011 demonstrated that 100% of the youth received a complete orientation to Scioto, which included information about how to access the grievance system. We agree that the State provides youth an orientation upon their admission to Scioto. However, we are concerned that the grievance process is not fully explained to youth during that time. As addressed above in section D.1, it appears that youth do not receive a full explanation about how all grievances are handled. Specifically, the State fails to explain to youth that the CIO investigates grievances about staff misconduct. Further, it does not appear that youth understand that the CIO automatically investigates all grievances. Such information is vital, as it will educate youth that Scioto takes all grievances seriously.

Compliance Rating: Partial Compliance

Recommendations for reaching Substantial Compliance: See recommendations under D.1

D.3 GRIEVANCE PROCESS

Without any staff involvement, youth shall easily be able to obtain grievance forms and submit grievances. (See Consent Order III.D.3)

In order to assess this provision, we reviewed the State's self-assessment, interviewed youth, and visited the living areas of youth. Consistent with our various on-site compliance tours in 2010, we found grievance forms and locked boxes located throughout Scioto. We also found that the grievance forms are readily accessible to youth without any staff involvement. Youth interviewed acknowledged knowing how to obtain a grievance form and how to submit that form. The State has maintained its substantial compliance rating with this provision.

Compliance Rating: Substantial Compliance

V. SPECIAL EDUCATION

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.A. §§ 1400-1482 (West 2000 & Supp. 2006), and regulations promulgated there under, and this Stipulation. (See Consent Order III.E.1)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed youth and staff. Consistent with our visit in October 2010, it is evident that the State takes seriously its responsibility to provide all qualified youth confined at Scioto an adequate special education. Accordingly, we determined that, for the most part, the State has a sufficient foundation for an effective special education program at Scioto. In our Second Compliance Report, we detailed our shared concerns with Dr. Dedel about: (1) whether the State is providing youth in disciplinary isolation regular, dependable access to class assignments and instruction, and (2) the extent to which the ABC (in-school suspension program) is implemented effectively. We note that this Court recently ruled in the SH v Stickrath matter that the State is required to develop policies and procedures for

Alternative Education Opportunities ("AEO") for youth in seclusion. In general, the State now provides educational services to youth as soon as possible after the onset of seclusion, contrary to the 10-day wait time applied previously. We look forward to assessing this aspect in the future.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

We note that provision E.1 requires compliance with the IDEA, the related regulations and the provisions E.2-E.11 of the U.S. v Ohio Consent Order (oversight, special education upon intake, parent and guardian involvement, staffing, screening for special education, individual educational plans, vocational education, forwarding screening and assessment information, training and quality assurance and transition services). Substantial compliance with E.1, "Provision of Special Education," therefore partially depends upon the State reaching substantial compliance with provisions E.2 through E.11. Fortunately, not including E.1, the State is now in substantial compliance with eight of the remaining ten provisions, in partial compliance with the one remaining provision, E.7 (Individual Educational Plans), and in beginning compliance with one remaining provision, E.8 (Vocational Education). Below, we provide the State with specific recommendations with regard to provisions E.7 and E.8. We encourage the State to consider these recommendations and those made by Dr. Dedel throughout her Second SPED Report.

E.2 OVERSIGHT

The State shall provide adequate oversight of special education at the Facilities. (See Consent Order III.E.2)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed staff. Consistent with our October 2010 compliance tour, we found that the documentation provided by the State regarding its SPED policies and

procedures support finding that ODYS continues to provide sufficient oversight over the SPED program at Scioto. Specifically, the State has demonstrated that it has an oversight strategy that operates at both the external and internal level. As described by Dr. Dedel in her First SPED Report, both levels of oversight are impressive and underscore the State's dedication to achieving compliance with this provision. In Dr. Dedel's Second SPED Report, she details the regular communication and guidance the Special Education Director provides Scioto education staff. (See Dedel Second SPED Report at 5). The State has thus maintained substantial compliance with this provision. In our February 2011 compliance report, we rated the State as being in substantial compliance with this provision. We commend the State for maintaining this rating.

Compliance Rating: Substantial Compliance

E.3 SPECIAL EDUCATION UPON INTAKE

> *The State shall ensure that all students who qualify for special education services receive such services within a reasonable time following intake at the Facilities.* (See Consent Order III.E.3)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed youth and staff. Based on our review, we found that all 215 youth (100%) admitted from November 1, 2010 to February 1, 2011 were enrolled and attending school within 72 hours of their admission. Through its self-assessment, the State provided a detailed description of its efforts and process to ensure that all students who qualify for SPED receive such services upon admission. Consistent with our October 2010 tour, Dr. Dedel determined that the students' class schedules were properly constructed and reflected the services prescribed by the Individual Educational Plans ("IEPs") available at the time of the youths' admission to Scioto. (See Dedel Second SPED Report at 6). In our February 2011 Compliance Report, we rated the State as being in substantial compliance with this provision. We commend the State for maintaining its substantial compliance rating with this provision.

Compliance Rating: Substantial Compliance

E.4 PARENT AND GUARDIAN INVOLVEMENT

The State shall develop and implement policies, procedures, and practices to appropriately notify and involve parents or guardians in the provision of special education services, wherever possible. (See Consent Order III.E.4)

In our assessment of this provision, we reviewed the State's self-assessment and special education files, and interviewed youth and staff. Consistent with our findings in October 2010, we found that the State involves parents or guardians in the educational planning of Scioto youth. In October, we found documentation of attempts to contact parents or guardians via mail and telephone, with ample documentation about the response or lack of response by parents or guardians. We agree with Dr. Dedel's concern regarding the low compliance across the last three IEP progress reports. (This is discussed under provision E.7 below.) (See Dedel Second SPED Report at 7). In our February 2011 Compliance Report, we rated the State as being in substantial compliance with this provision. We commend the State for maintaining substantial compliance with this provision.

Compliance Rating: Substantial Compliance

E.5 STAFFING

The State shall develop and implement an education staffing plan to ensure adequate staff to comply with the terms of this Stipulation. (See Consent Order III.E.5)

In our assessment of this provision, we reviewed the State's self-assessment and we interviewed staff. Based on our review, we found that the State continues to use an adequate formula to ensure that it meets the 1:12 teacher-to-student ratio required by the Ohio Department of Education. Through the staffing plan, the State ensures that all students have full access to the education program at Scioto. We commend the State for its continued efforts to improve staffing under this provision. We note that during our November on-site tour, the speech language

pathologist and transition skills teacher positions remained open. As Dr. Dedel notes in her March 2011 Report, the State resolved this issue by contracting with an individual who already provides speech language pathology services at another facility. At the time of our February 2011 tour, the State had approved hiring an individual transition skills teacher. We commend the State on maintaining substantial compliance with this provision.

Compliance Rating: Substantial compliance

E.6 SCREENING FOR SPECIAL EDUCATION NEEDS

> *The State shall provide prompt and adequate screening of youth for special education needs and shall identify youth who, upon admission to the Ohio Department of Youth Services, were receiving special education in their home school districts or who may be eligible to receive special education services but have not been so identified in the past.*
>
> *The State shall ensure that those staff conducting the screening, assessment and evaluation processes are qualified to do so.* (See Consent Order III.E.6)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed staff. Consistent with our finding in our Second Compliance Report, we found the State's special education intake process to be appropriate and detailed. Specifically, the intake process requires youth to be interviewed and youth records to be immediately requested from the youth's prior schools. For those youth not currently eligible for special education upon entrance to Scioto, the State also has a detailed method to determine whether a referral is appropriate. During the November 1, 2010 to February 1, 2011 period, Scioto admitted a total of 215 students. Eighty-six students (40%) of the 215 were identified as needing special education services. During that time, 2 students in "regular" school were referred to the Intervention Assistance Team to identify a way to address academic difficulties and determine whether the youth is eligible for special education. We commend the State for maintaining substantial compliance with this provision.

Compliance Rating: Substantial Compliance

E.7 INDIVIDUAL EDUCATION PLANS

> *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.*
>
> *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 students' 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.* (See Consent Order III.E.7)

In our assessment of this provision, we interviewed staff and reviewed the State's self-assessment. In our Second Compliance Report, we explained that the ODYS IEP procedures were sufficiently detailed, and were followed in most areas. Further, most IEPs were of adequate quality. However, as further discussed by Dr. Dedel, the quality of the annual IEP goals and the progress reports to parents[14] are still of concern. (See Dedel Second SPED Report at 10-11). We are encouraged that the State has taken on corrective action, such as: (1) training and development for special education staff in the areas of measurable goal writing and monitoring student progress, (2) requiring all progress reports to be scanned, and (3) having education staff review draft IEP language before the IEP meeting to improve the quality of the IEP goals. We look forward to assessing this provision during our next compliance tour. We are hopeful that these changes improve IEP development and implementation.

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[14] According to Dr. Dedel's Second SPED Report, the State reported low compliance levels with sending progress reports. Specifically, the State's compliance level for October 2010 was 30% and only 9% in January 2011.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

We suggest the State continue its current revisions of IEP goals to ensure that they are clear, appropriate, and assist in monitoring the youth's progress. Further, we agree with Dr. Dedel's suggestion that the State conduct a more in-depth review of the 10 sample student reviewed for the State's self-assessment. Dr. Dedel suggests determining why less than 50% of the 26 goals were not met for these youth. (See Dedel Second SPED Report at 11).

E.8 VOCATIONAL EDUCATION

> *The State shall provide appropriate vocational services that are required transition services for disabled youth under the IDEA.* (See Consent Order III.E.8)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed youth and staff. Consistent with our finding in October 2010, the State provides one vocational class, Administrative Office Technology, as its vocational services to youth. Apparently, obstacles to expanding the course offerings include financial constraints, and youths' short lengths of stays. During our October 2010 tour, the State informed us that the ODYS Superintendent was aware of the lack of vocational options and was researching alternatives, such as short-term vocational courses that involve some level of certification. During our most recent tour in February 2011, however, the State informed us that those plans had been cancelled. We are concerned and disappointed at the State's lack of improvement. Considering the very likely increase in population and longer lengths of stay for that population, due to the closing of the ORV, we encourage the State to add vocational education as soon as feasible. Based on this review, the State is in beginning compliance with this provision.

Compliance Rating: Beginning Compliance

Recommendation(s) to reach substantial compliance:

We believe that Dr. Dedel's comment from her First SPED Report that "the dearth of meaningful career-oriented options for students at Scioto is problematic" remains appropriate. (See Dedel First SPED Report at 22). Again, we recommend that the State reach out to local resources to enrich its program while it takes other steps to bolster its vocational course offerings. As the State reinvigorates its vocational services, it may wish to have vocational educators from other facilities visit, if only for introductory classes. The State may wish to inquire if nearby community colleges have online courses that the Scioto youth could audit. Additionally, since Scioto has a well-established volunteer program, the State may wish to inquire into whether any volunteers could provide presentations about their own jobs — for example, small business owners — and what education or training they needed, again if only to introduce youth to possible career options. We look forward to re-assessing this provision during our next compliance tour.

E.9 FORWARDING SCREENING AND ASSESSMENT INFORMATION UPON TRANSFER

> *The State shall ensure that, when a youth is discharged from the Facilities before the interventions or educational evaluations required in Section III.E.6 above are complete, the Facilities shall forward to the superintendent of the youth's receiving school district all information regarding screening and evaluations completed to date, noting what evaluations are yet to be performed.* (See Consent Order III.E.9)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed staff. Based on our review, we verified that, consistent with ODYS policy, staff regularly forward educational records to receiving schools when a youth is transitioned out of the ODYS system. During our February 2011 tour, we learned that during the period from November 1, 2010, to February 1, 2011, six youth were referred for testing or re-evaluation to determine eligibility for special education. While the six youth were referred out of Scioto prior to the completion of testing, the State reported that it had successfully forwarded the students' records to the

receiving school districts. We commend the State on maintaining substantial compliance with this provision.

Compliance Rating: Substantial Compliance

E.10 TRAINING AND QUALITY ASSURANCE

> *The State shall design and implement annual training requirements for special education staff.* (See Consent Order III.E.10)

In our assessment of this provision, we reviewed the State's self-assessment and interviewed staff. Consistent with our finding in our Second Compliance Report, the State's comprehensive training program offers to teachers valuable opportunities to further develop skills and effectively incorporate new techniques into their teaching. We commend the State for providing relevant training to its education staff and for working with an educational consultant to provide additional skill-building opportunities. We were impressed that, in response to Dr. Dedel's concern about training in behavior management techniques, ODYS invited a consultant to provide two training sessions on the use of SBBMS. (See Dedel Second SPED Report at 4).

We commend the State for maintaining its substantial compliance rating.

Compliance Rating: Substantial Compliance

E.11 TRANSITION SERVICES

> *The State shall comply with any IDEA requirements for providing transition assistance. The State shall provide transition assistance to students by providing counseling and concrete information regarding appropriate community resources, and how to pursue post-secondary options, re-enroll in school or complete the GED.* (See Consent Order III.E.11)

In our assessment of this provision, we reviewed the State's self-assessment and we interviewed staff. Based on our review, it appears that the State continues to have a solid foundation in place to provide transition services to Scioto youth.

During the time period from November 1, 2010, to February 1, 2011, 13 youth were released from Scioto and 92% (12 of the 13) reportedly worked with the transition coordinator. Scioto has a "Transition Skills" course designed to encourage youth to join the workforce and ensure they have access to necessary documentation in order to apply for employment. Scioto also has a position, "Transition Coordinator," which tasks an individual with assisting youth to interact with outside resources to smooth the youth's re-entry back into the community. As of the date of our February 2011 compliance tour, the second transition skills instructor was not filled. It is our understanding that the State had already identified an individual and anticipates filling the position in the near future. Based on this assertion and the high rate of compliance, we consider the State to be in substantial compliance.

Compliance Rating: Substantial Compliance

VI. PROGRAMMING

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 poses an immediate risk of harm to self or others; (c) following an adequate disciplinary hearing, pursuant to an appropriate disciplinary sanction. 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.* (See Consent Order III.F.1).

In order to assess this provision, we reviewed the State's self-assessment, and interviewed staff and youth. Consistent with our Second Compliance Report, the

State continues to have a significant programmatic framework to reduce idleness and provide structured opportunities for most youth. The State intends to create a programming tracking system, called "Youth Activity Tracking" ("YAT"), which will track individual level programming and may be a mechanism to detect trends in attendance, hold YS staff and unit managers accountable, and assist in determining whether all youth receive equal access to programming and SBBMS positive reinforcements. We commend the State for its continued success and improvements in its programming efforts and we look forward to learning more about the YAT once implemented.

Despite the State's variety of programming and high level of volunteer activity, during our February 2011 tour we again received youth complaints that not all youth have full access to all programming opportunities or benefit from the full range of rewards under the SBBMS program. We received similar complaints from different housing units. In particular, youth alleged that they receive insufficient notice from YS staff about available programming. While the facility has a set calendar of programming events posted on the unit, it is unclear how youth actually sign up for events. In an effort to curb youth frustration and/or concerns, we suggest the State formalize the process in order to make it more transparent. In any event, every effort should be made to include interested youth in programming, while not compromising youth or staff safety in transporting youth to activities.

Other complaints we received during our February 2011 tour included allegations from reception youth that not all programming opportunities are available to them. The same youth also claimed that they do not receieve the full benefit of the SBBMS program. Specifically, the youth reported that the only rewards offered to them are either an extra envelope for writing a letter home, a board game to play (which are often broken or missing pieces), or a later bedtime. Lastly, still other youth on other units complained about YS staff overusing early

bed time ("EBT"), itself a form of seclusion, to avoid interacting with certain youth or to show their disfavor for youth. These youth alleged that the EBT is used for even small transgressions or applied to all youth on a unit even when the misconduct involved only one or two youth. These allegations, if true, are concerning because they tend to support other claims that some YS staff impose punishments without cause against disfavored youth. We note that documentation we reviewed also support this belief. Specifically, one set of interdisciplinary team minutes we reviewed expressly confirm that "units have 'heavily used the consequence of no free time'…early to bed is also being used too often.'" (See Glindmeyer Second Mental Health Report at 11). We strongly suggest that the State track the use of EBT based on youth who received EBT, unit, staff person who imposed the EBT, time of the EBT, and alleged misconduct that led to the EBT. These data should be assessed as part of the facility's larger quality assurance activities. Dr. Dedel notes in her most recent report that assignments that merely consume time without any substantive message are not effective behavior management tools. (See Dedel Third PFH Report at 19).

Lastly, based on Dr. Dedel's review of 20 Re-Entry plans, we found that most non-treatment related parole eligibility requirements from the Release Authority were generic, such as following rules, developing social skills, decision making, attending school, and engaging in pro-social leisure time. We found that most of these parole eligibility requirements were met by the State's programming or educational opportunities. (See Dedel Third PFH Report at 19). The remaining parole eligibility requirements, namely those that were treatment-related, are discussed under provisions B.5 (Adequate Mental Health Care and Treatment), and provision B.8 (Integrated Treatment Plans,) which address group and individual therapy opportunities and interdisciplinary treatment teams. In summary, the State's group and individual therapies are still in the early stages of development and implementation. While some mental health staff demonstrate a strong dedication and creativity in providing such therapies and treatment, the State's

progress is delayed due to its lack of sufficient mental health staff and the fact that YS staff are not yet fully integrated into the treatment process. Accordingly, the State has met the non-treatment related parole eligibility requirements only.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

The State should: (1) ensure all youth have access to, and are offered, programming, consistent with safety precautions, (2) examine the use of sanctions such as EBT to determine relevancy and appropriateness to misconduct by youth, and (3) ensure the SBBMS program is fully implemented, especially the use of character coupons, throughout Scioto.

F.2 ORIENTATION

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 the facility's programs. (See Consent Order III.F.2(a))

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. (See Consent Order III.F.2(b))

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. (See Consent Order III.F.2(c))

In our assessment of this provision, we interviewed youth and reviewed policies and procedures and the youth handbook, last revised in October 2010.

Admission Intake and Orientation

The youth intake and orientation process at Scioto provides youth with an adequate overview of institutional rules, the process for accessing mental health and medical care, and the available opportunities in treatment, recreation, and educational programs. However, as described under provisions D.1 and D.2, the orientation regarding the grievance process is incomplete and should be revised to provide all relevant information to incoming and already admitted youth.

Similarly, the handbook and orientation do not adequately explain youths' rights regarding religious practices. As quoted above, F. 2 requires the State to develop an orientation that clearly sets forth the rules youth must follow at the facility and provides other information pertinent to the youth's participation in the facility's programs. It also requires that the facility provide rules in writing and an introductory handbook. The handbook claims to "contain information [youth] will need to know during [their] stay at ODYS." (page 6 of youth handbook). While the handbook informs youth that they have the right not to be discriminated against because of religion, the section covering "Religious Services" may not fully comply with the Religious Land Use and Institutionalized Persons Act, 42 U.S.C. § 2000cc ("RLUIPA"). RLUIPA protects the religious exercise of persons confined to institutions, including youth confined in juvenile correctional facilities. [15] RLUIPA prohibits the State from substantially burdening the religious exercise of youth in juvenile correctional facilities, even if the burden results from a rule of general applicability.[16] Regulations amounting to a substantial burden will only be

[15] See http://www.justice.gov/crt/about/spl/rluipa.php (last visited January 12, 2011).

[16] For example, while the youth handbook states that youth who wear "[p]ersonal clothing not authorized by the state" will be subject to discipline (page 21), RLUIPA

permitted if the State demonstrates that the regulation furthers a "compelling government interest" and is the least restrictive means available to further that interest. We encourage the State to seek clarification from the United States if it should have any questions about RLUIPA.

Notice to Youth of Facility Rules and Incentives/Consequences for Compliance.

Based on our review of the youth handbook and interviews with youth, it appears that, upon intake, youth receive notice about Scioto facility rules and incentives/consequences for compliance. Specifically, youth were able to articulate the SBBMS system.

Introductory Handbook, Orientation and Reporting Abuse.

In our Second Compliance Report, we recommended that the State revise its handbook to be consistent with its religious accommodations procedure, SOP 507.02.06, which requires a youth to fill out and return a "Request for Accommodation of Religious Belief or Practice" form if he or she wishes to have an accommodation for a religious rite, practice, or observance. However, the youth handbook fails to mention this form in the section which discusses religious services. The handbook is thus incomplete and should be revised to describe the procedure for seeking a religious accommodation consistent with the SOP. One youth we interviewed alleged that she was prohibited from wearing religious garb that posed little safety risk, grieved about the infringement, but was never informed of her right to seek a religious accommodation. Ultimately, staff returned the youth's garb to the religious advisor and allegedly told the youth that if she were allowed to wear the garb, all other youth would have to be allowed to wear baseball caps.

Compliance Rating: Partial Compliance

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may require that a Jewish youth be permitted to wear a yarmulke or a Muslim youth be permitted to wear a hijab in observance of his or her religious practices.

Recommendation(s) to reach substantial compliance:

As discussed in more detail in our Second Compliance Report, the State should revise its handbook to be consistent with the State's religious accommodations policy, ensure that all relevant personnel are familiar with RLUIPA's requirements, and ensure that the chaplain is familiar with the requirements of RLUIPA.

VII. DOCUMENTATION

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.* (See Consent Order III.G.1).

In order to assess this provision, we reviewed the State's policies, procedures, and practices regarding progress notes. We recognize that the provisions under G, "Documentation," do not fall squarely under any of the other sections, but rather touch on mental health, medical care, and education. For this reason, we asked our medical and mental health experts to comment on these provisions. In our Second Compliance Report, we recommended the State provide a discussion in its self-assessment of how it meets the criteria of provisions G.1 and G.2. The State did not provide any such self-assessment.

In preparation for our compliance tour in November 2010, the State provided a draft policy, entitled "Behavioral Health Documentation Guidelines," relevant to

our assessment of mental health progress notes. While the policy appears to adequately meet the requirements of provision G.1, in our Second Compliance Report, we noted that it was unclear whether this policy had been implemented. A review of youth records in November 2011 revealed that mental/behavioral health progress notes were generally of fair quality. During our most recent compliance tour in February 2011, we found that progress notes in the youth records revealed some improvement in the documentation of group interaction. We agree, however, with Dr. Glindmeyer's observation that, in the context of integrated treatment plans, the progress notes reviewed did not consistently relate to treatment goals and/or document the response or lack thereof to prescribed interventions. (See Glindmeyer Second Mental Health Report at 13). In fact, during the verbal self-assessment on-site, the mental health administrative staff recognized that the progress notes that related to integrated treatment teams were in the beginning stages of implementation. (See Glindmeyer Second Mental Health Report at 13-14). Consistent with our Second Compliance Report, while we found that the youth records contained numerous progress notes, the progress notes did not consistently address the youth's specific treatment goals as outlined in treatment planning documents.

The relevant medical forms, policies and SOPs remain the same since our last review. The policies and SOPs appropriately address content organization and format, confidentiality requirements, and health care professionals' access to records. Physicians and nurses appropriately document progress notes in chronological order in youth health records. The Medical Release and Transfer Summaries Policy require health staff to complete a Medical Transfer Summary and a Medical Release Summary for youth who are discharged or transferred out of the facility. Both forms contain lines to document required or scheduled medical and dental referrals. The Medical Release form also designates whether psychiatry follow-up is required immediately or within another timeframe, and whether a

parent should be advised. Medical staff adequately document health information on the above-mentioned documents according to policy.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

The State should implement quality assurance measures, a peer review process, and clinical supervision to improve the consistency and quality of mental/behavioral health progress notes.

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.* (See Consent Order III.G.2)

While health records include psychiatric evaluations and chronological psychiatric progress notes, records still do not include psychological records, such as case notes. As stated in Section C.2. ("Health Records"), the State must continue moving towards a system that will combine all health records, including psychology records.

Compliance Rating: Partial Compliance

Recommendation(s) to reach substantial compliance:

Until the State combines these records, treatment teams will not have prompt access to relevant, complete, and accurate documentation regarding the youth's status.

THIRD COMPLIANCE REPORT

As per section VII.E of the Consent Order, the U.S. v Ohio Stipulation terminates three years from its effective date, June 5, 2008. The State has not yet reached substantial compliance with all 53 provisions in the agreement. Accordingly, the United States and the State of Ohio are currently negotiating a possible extension of the U.S. v Ohio agreement.

Respectfully submitted this 9th day of May, 2011.

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Attachment A

U.S. Department of Justice v. The State of Ohio
Civil Action No: 2:08-cv-475

3rd Protection from Harm Compliance Report

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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). The Stipulation adopted the same monitoring team used in a concurrent suit, *S.H. et al., v. Tom Stickrath (S.H.)*, led by Fred Cohen, Esq. This team was charged with monitoring the extent to which the State had effectively implemented the reforms required by the Stipulation and providing detailed reports to the Parties. After the Stipulation was signed, the State closed the Marion facility.

In late 2009, Mr. Cohen announced his intention to resign his position as the Monitor for the Stipulation, while continuing his duties as the lead monitor in *S.H.* On November 23, 2009, the Parties amended the Stipulation to assigning monitoring duties for Scioto to the DOJ. Both Parties agreed that I, Dr. Kelly Dedel, would serve as the DOJ's expert for protection from harm and special education issues.

This is my third report on the 12 protection from harm related provisions. The DOJ opted for my assessment to be conducted remotely, and thus, while the State provided a large volume of useful information, I was limited in the extent to which I could verify the State's data or delve further into certain issues. This report draws on the State's self-assessment materials submitted in late February 2011 and a series of follow-up telephone calls and emails with various Scioto staff. For the sake of brevity, I have not reiterated information from previous reports that testified to the State's compliance with each provision (e.g., discussions of policy and procedure; data analysis from previous monitoring periods; etc.). The reader is encouraged to read my 2nd Compliance Report for a complete discussion of these issues.

In March, 2011, the Ohio Legislature indicated its intention to close the Ohio River Valley (ORV) facility. The closure of this facility and the subsequent transfer of youth to other facilities in the State will have a significant impact on Scioto's ability to sustain its progress in making the required reforms. The transfer of youth must be carefully planned and managed so that the negative outcomes experienced during the closure of other DYS facilities may be avoided. The State is encouraged to share its plans for the transfer of youth to Scioto and how its previous experiences with facility closures will inform the upcoming reassignment of youth and redeployment of staff.

Section V.H of the Stipulation requires the Monitor/expert to provide the Parties with reports "describing the steps taken by the State to implement [the] Stipulation and to evaluate the extent to which the State has complied with each substantive provision of the Stipulation." The full text of each provision is provided in the following report, along with a detailed discussion of the State's progress in each area. The report content required by the Stipulation is presented in *italics* below, along a description of the content in each section:

- *"The self-assessment steps the facility undertook to assess compliance and the results thereof*." In response to a detailed document request I crafted to focus on specific performance measures for each provision, the State presented a large volume of information and data to demonstrate its progress in meeting the requirements of the Stipulate to date. This information is summarized.

- *"[My own] steps taken to assess compliance*." Because I did not travel to Scioto, I did not take any independent actions to assess compliance, other than to ask clarifying questions about the State's self-assessment or to analyze the data contained in it.

- "*Recommendations for facilitating or sustaining compliance*." These recommendations are generally outcome-focused so as to reinforce the spirit of the provision itself, but also to permit the State sufficient flexibility to satisfy both this Stipulation and the requirements of *S.H.* The recommendations in this section are limited to those needed to demonstrate substantial compliance with the provision. Other recommendations toward best-practice are included in the discussions of each provision, but are not necessarily required for substantial compliance in my opinion.

- *"Sources of information that form the basis of [my] opinion*." The self-assessment documents were organized by provision, and referenced accordingly.

Given that the DOJ has been appointed as the Monitor in this case, I have not offered specific compliance ratings for each of the provisions. Instead, I endeavored to describe the current state of affairs in each area as indicated by the State's self-assessment materials, along with my assessment of the steps needed, if any, for the State to meet the requirements of the provision.

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.	
Self Assessment	The Chart in Appendix 1 shows the rate of youth violence at Scioto for the past 12 months. Since May 2010, the facility's rate of youth violence has increased, compared to the rates of violence in 2009 and early 2010. This trend was noted during my visit to Scioto in November 2010, when I recommended that the State delve into these data to determine the underlying causes of the increases. The resulting analysis was of very high quality and illuminated some important facility dynamics that needed to be addressed. First, instability in staffing among the facility's social workers, psychologists, psychiatrists, and Unit Managers appeared to underlie the increased rates of violence witnessed in the girls Mental Health unit and the boys Reception units. Not only did the instability disrupt the relationships between youth and staff that are fundamental to maintaining a safe facility, but the social worker shortages in Reception also caused a delay in completing required assessments, thus increasing the lengths of stay. (Reception units tend to have more violence because youth have not "settled in" and are anxious about their subsequent placements. An efficient transfer process to the youth's permanent facility is essential.) Further, in addition to increasing the number of boys assigned to the mental health unit from 7 to 15 youth, instability in the Unit Manager position for that unit meant that direct care staff supervision lacked structure and consistency. Similar problems plagued the girls' Mental Health unit, where the psychologist was absent for several months. In short, the facility's struggle to maintain a consistent and stable workforce contributed in very tangible ways to the increased rate of violence witnessed during the last half of 2010. In addition, as is typical in most facilities, the facility found that a relatively small number of youth were responsible for a vastly disproportionate amount of violence. Just 12 youth accounted for 64% of the total number of seclusion hours for the entire facility. Unfortunately, given the instability in staffing discussed above, many of these youth did not have Special Management Plans designed to address the underlying causes of their aggressive behavior. Once armed with this information, the facility took steps to address the underlying causes of the increases in youth violence. A new Unit Manager was assigned to the boy's mental health unit. According to my colleagues who were on site at Scioto (DOJ attorneys and Dr. Daphne Glindmeyer), the current Unit Manager received very positive reviews from the youth on that unit. Further, the State was authorized to pay overtime to social workers on the Reception units in order to address the backlog of assessments so that youth could move through the reception process more quickly. Finally, the Deputy Superintendent implemented a monthly data review with each Unit Manager. Those overseeing units housing youth with chronic violent misconduct are expected to discuss

	each youth's Special Management Plan during that meeting. The problem-solving capability demonstrated by the analysis discussed above is exemplary. Moving forward, the facility should continue to assess the level of stability among the various professional groups at Scioto, the length of stay in the Reception units, and the extent to which Special Management Plans effectively suppress the aggressive behavior of identified youth. If each of these strategies is properly implemented, the rate of youth violence should decrease. If it does not, other dynamics are likely in play and the problem-solving process should be reinstituted to identify and respond to these issues. In addition, my colleagues on site at Scioto (DOJ attorneys and Dr. Daphne Glindmeyer) heard multiple reports from youth about abusive language by staff (See DOJ's letter dated March 11, 2011, page 2). Approximately half of the 25 youth interviewed reported that certain staff regularly berated, antagonized, cursed, or otherwise verbally abused them. Dr. Daphne Glindmeyer observed such treatment of a youth in seclusion by a staff member who was shouting inappropriate comments to the youth through the door of the seclusion room. While the youth reported that some staff would intervene with staff displaying inappropriate conduct, for the most part, youth felt that Administrators were disconnected from what was happening on the units and that Unit Managers were too busy to hear or address their complaints. That these complaints about abusive language were so pervasive among the youth interviewed is a serious concern. The facility should take steps to identify the staff who engage in such behavior and should intervene with appropriate training or discipline as needed. Other topics covered by this provision—restraints, inappropriate relationships, and seclusion—are discussed in the specific provisions below.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	To reach substantial compliance, it is recommended that the State: 1. Investigate and address staff's inappropriate and verbally abusive language toward youth. 2. Reach substantial compliance with the other provisions related to protecting youth from harm.
Sources of Information	▪ Self-Assessment materials for Provision 1, prepared at my request ▪ Follow-up telephone conversations with the Deputy Superintendent ▪ Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

III.A.2 Use of Force. The State shall develop and implement comprehensive policies, procedures, and practices limiting use of force on youth to situations where it is objectively reasonable and necessary. Staff shall be required to adequately and promptly document and report all uses of force.

Self Assessment

Staff training on the proper use of physical and mechanical restraints is comprehensive and exceeds the generally accepted practice in this area. Managing Youth Resistance (MYR) training is conducted quarterly. In each of the four quarters in 2010, at least 90% of all staff attended the training (Q1 96%; Q2 90%; Q3 94%; Q4 96%).

As shown in the table below, the rate of physical restraint decreased approximately 16% in the latter part of 2010 (average rate .47) as compared to the first six months of the year (average .56). These monthly data are also presented in Chart 2 in the Appendix, along with data on the use of mechanical restraints.

Rate of Physical Restraint, February 2010 through January 2011			
Month	Number of Restraints	Average Monthly Population	Rate of Physical Restraint
Feb 10	44	119	.40
Mar 10	56	140	.40
Apr 10	69	139	.50
May 10	81	134	.60
Jun 10	80	125	.64
Jul 10	108	128	.84
		Average Rate	*.56*
Aug 10	64	122	.53
Sep 10	57	131	.44
Oct 10	62	128	.48
Nov 10	64	133	.48
Dec 10	75	150	.50
Jan 11	56	139	.40
		Average Rate	*.47*

The reason for this decrease is unknown, but is worthy of investigation so that the factors leading to the decrease can be harnessed to produce additional reductions in the use of force. In particular, it would be useful to know whether the decreases have occurred in situations involving youth-on-youth violence or in those involving disruptive behavior.

The State provided data on the proportion of physical restraints in which the youth remained standing, versus those in which the youth is taken to the ground. These data illustrate the staff's efforts to temper their use of restraint,

	using the minimum amount of force necessary to control the youth's behavior. Over the past six months, youth were taken to the ground in only 15% of all physical restraints. This is very encouraging. According to my colleagues who were on-site at Scioto, youth who had been at Scioto multiple times noticed an improvement in staff's commitment to de-escalating tensions, rather than proceeding directly to the most restrictive forms of physical restraint. Of course, there will always be situations in which staff do not conform to the expectation that only the minimum amount of force is used to regain control of youth. As discussed in the provision related to Investigations, below, the facility appears to have adequate measures for screening incidents involving the use of force and for referring those with questionable practices for further inquiry. The two incidents reported to my colleagues on-site at Scioto had already been identified by the facility for investigation by the Chief Inspector's Office.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's policies, procedures and practices related to the use of force appear to meet the requirements of this provision.
Sources of Information	▪ Self-Assessment materials for Provision 2, prepared at my request ▪ Follow-up telephone conversations with the Deputy Superintendent ▪ Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

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.	
Self Assessment	The State presented data related to the three main types of seclusion that are used at Scioto: 1) Regular Seclusion—a period of isolation imposed in response to non-violent misbehavior, usually between 1 to 3 hours in duration; 2) Pre-Hearing Seclusion—a period of isolation immediately following youth's involvement in aggressive behavior. The duration is determined by the youth's score on the IRAV Assessment; and 3) Disciplinary Seclusion—a period of isolation imposed by a Hearing Office as a sanction for aggressive behavior. *Regular Seclusion* Over the past 9 months, the number of regular seclusions ranged between 35 and 57. While there were fluctuations from month to month, there were no clear patterns—the average number of seclusions for each of the 3-month periods was 47. The rate of regular seclusion ranged between .3 and .5 seclusions per youth per month, a statistic which is difficult to interpret given that some youth are never secluded, while others are secluded multiple times. In general, the rate of regular seclusion is not particularly alarming, mainly because the majority are quite short. Over the past 6 months, nearly all seclusions (98%) lasted less than three hours, with 31% lasting under one hour. Given the facility's commitment to reducing seclusion hours facility-wide, it would be worth identifying the youth who are secluded often to determine whether an alternative method of de-escalation might be as effective (it may not be—for some youth, a short time alone in their rooms is exactly what is needed for them to regain control of their behavior). *Pre-Hearing Seclusion* When youth are involved in violent misconduct, they are immediately confined to their rooms. Within 4 hours, their risk of subsequent misconduct is assessed using the IRAV assessment tool, which provides guidance as to when these youth may be safely returned to the general population. IRAV data for the past 6 months show that of the 219 youth placed in pre-hearing seclusion, nearly half (46%) were classified into the C category (pre-hearing seclusion is authorized for 4-24 hours), one-third (35%) were classified into the B category (pre-hearing seclusion is authorized for 24-56 hours), and one-fifth (19%) were classified into the A category (pre-hearing seclusion is required until the disciplinary hearing is held). In other words, approximately 80% of youth who engaged in violent misconduct were NOT required to remain secluded pending their disciplinary hearing. This is a massive change from several years ago when ALL youth were required to remain in pre-hearing confinement pending their disciplinary hearings. Among those eligible for release, approximately two-thirds remained in pre-hearing seclusion for less than 24 hours (November 67%, December 57%, and

January 65%). Again, this is a significant improvement from the era of CRAV, when youth commonly spent several days in seclusion awaiting their disciplinary hearings.

When reviewing the State's data, I noted a change in the proportion of youth who spent less than 24 hours in pre-hearing seclusion as compared to my last visit, when 85-90% of youth were released prior to the 24-hour mark. It turns out that the facility accidentally implemented the IRAV policy improperly. Instead of abiding by the requirement for B category youth to remain in seclusion for 24-56 hours, they released them from pre-hearing seclusion immediately. Interestingly, many of these B category youth quickly became involved in subsequent misconduct once released to the general population. In effect, the facility re-validated the IRAV classification system, and confirmed the compelling safety risks posed by youth scoring in the B category. In November, the facility adjusted its practices to conform to the IRAV policy. This experience highlights the importance of regularly compiling and reviewing data related to the various provisions. Outliers in the data and anomalies like "90% of youth were released prior to the 24-hour mark" should be immediately analyzed to determine the underlying causes.

Disciplinary Seclusion

Over the past 6 months, the use of disciplinary seclusion has been relatively low when compared to the number of incidents involving youth-on-youth violence. In contrast to prior years when ALL youth involved in violent misconduct were placed in disciplinary isolation, seclusion is now imposed in about 60% of these incidents. The other 40% received an alternative consequence of some sort. This is a very positive development.

Over the past 6 months, approximately 17% of disciplinary seclusions lasted 24 hours or less; 56% lasted between 24 and 72 hours; and 26% lasted over 72 hours. While this variation is encouraging and suggests that the severity of the consequence is calibrated according to the severity of the incident, the facility is encouraged to continue its efforts to reduce the length of stay in seclusion. As discussed at length in my previous reports, isolation can only suppress behavior—it does nothing to address the underlying causes of the behavior. Attending to these underlying causes requires the youth to be engaged with the regular facility programming, and the sooner this can happen, the better.

Seclusion and the Risk of Self-Harm

The facility continues to address the problem of staff not conducting required safety checks to verify the welfare of youth who are in seclusion or locked in their rooms overnight. Videotaped footage of the housing units' operation is reviewed on a regular basis. The State produced data indicating that of the 17 shifts reviewed over the past 3 months, 8 of the 17 (47%) revealed problems with staff attentiveness and their conducting required safety checks. Half of the problems occurred in November, while improved compliance was noted in December and January. However, when one of the DOJ attorneys reviewed

	videotape while on-site, significant problems were noted. On February 7th, staff assigned to the unit reviewed did not make ANY safety checks between midnight and 6am, nor did the Operations Manager (OM) make rounds during that six hour period. [The State is looking into compliance with safety checks from 10pm to midnight of that same shift.] Further, my colleagues on site heard multiple complaints from youth about staff refusing or delaying their access to the restroom during the overnight hours. In some cases, these youth alleged they urinated in their rooms or on themselves (See DOJ's letter dated March 11, 2011, page 3). Clearly, staff compliance in this area needs additional improvement. Notably, around the holidays, the videotape reviews indicated the rates of compliance with safety check policies appeared to be quite good. The reasons for this improved level of compliance, particularly during a time in which staff compliance generally falls off, is unknown but is definitely worth investigating. Identifying the reasons that the problem does NOT exist is an important problem-solving activity.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	It is recommended that the State: 1. Ensure that staff conduct the required safety checks any time that youth are confined to their rooms, particularly on 3rd shift.
Sources of Information	▪ Self-Assessment materials for Provision 3, prepared at my request ▪ Follow-up telephone conversations with the Deputy Superintendent ▪ Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

III.A.4 Restraint. The State shall develop and implement policies, procedures and practices so that only safe methods of restraint are used at the facility and only in those circumstances necessary for safety and security and, to the extent possible, when less restrictive means have been properly, but unsuccessfully, attempted or with respect to therapeutic restraints pursuant to a medical order to protect the health of the youth.	
Self Assessment	As discussed in Provision 2, above, staff training on the proper use of physical and mechanical restraints is comprehensive and exceeds the generally accepted practice in this area. Managing Youth Resistance (MYR) training is conducted quarterly. In each of the 4 quarters in 2010, at least 90% of all staff attended the training (Q1 96%; Q2 90%; Q3 94%; Q4 96%). As discussed in my previous report, the State has implemented several procedures to screen incidents involving physical restraint (e.g., review by the Operations Administrator, review by the Facility Intervention Administrator (FIA) and the Superintendent's Monthly Review) and to refer those with questionable practices for further inquiry. In November and December 2010, 10 incidents were referred for investigation to determine whether the use of force was inappropriate or excessive. Of these, only one was substantiated (#5501100358—staff was cited for picking a youth up in a bear hug and tossing him aside, when he should have taken more care to gently move the youth away from the altercation. The staff received a verbal reprimand for this incident). Two more recent incidents were discussed during the teleconference debriefing with Scioto administrators on February 25, 2011. Both incidents were identified via the screening processes discussed above and referred for investigation.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The facility's policies, procedures and practices related to Restraint appear to meet the requirements of this provision.
Sources of Information	• Self-Assessment materials for Provision 4, prepared at my request • Follow-up telephone conversations with the Deputy Superintendent • Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

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 staff 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.	
Self Assessment	The State submitted a chart detailing the number and type of incidents that were investigated over the past three months. Of the 15 investigations, 10 alleged the inappropriate or excessive use of force, one alleged verbal abuse by staff, and 4 alleged inappropriate relationships between staff and youth. No youth alleged physical abuse by staff during the past three months. Their various allegations of physical harm occurred during an incident involving physical restraint and thus were counted in the inappropriate/excessive use of force category. Although not required but good practice, in most of these situations, staff submitted suspected child abuse reports to local law enforcement and the child protective services agency. One of the use of force allegations was substantiated (discussed in the previous provision) and one of the inappropriate relationship allegations was substantiated (#1001100101—staff received a written reprimand for inappropriate contact with youth (hugging) and inappropriate comments ("I love you").
Steps Taken to Assess Compliance	I performed a content analysis of the 15 investigations submitted among the self-assessment materials. Nine of these investigations were conducted by the Chief Inspector's Office (CIO), and 5 were conducted by Scioto staff. The investigations conducted by the CIO were high-quality and completed within the required timelines. However, several of the investigations conducted by Scioto staff were of poor quality. In general, the investigatory protocol (e.g., types of questions asked, pursuit of additional witnesses or evidence, confronting witnesses with inconsistencies, etc.) lacked the necessary vigor to ensure a reasonable finding. Two of the investigations were very poorly written, to the point that it was difficult to discern the basis for the investigator's conclusions. These particular deficiencies were not evident in my previous investigation of this issue, although there was a problem with timeliness. I do not know the source of the current problem. A Scioto administrator reported that the CIO's most recent audit revealed similar problems. In response, the CIO plans to offer investigation training to designated Scioto staff. Further, the facility administrator who oversees the investigations has begun to review each investigation and to request clarification and corrections from the assigned investigator. Additionally, my colleagues on site at Scioto interviewed two youth who had been the alleged victims in two incidents that were investigated by the CIO. In

	both cases, the youth reported threats and intimidation by staff once the youth's allegations became known (see DOJ's letter dated March 11, 2011, page 2). In one case, an uninvolved staff verbally threatened to harm "anyone who tried to mess with my money [her job]." In the other case, other youth on the unit reported to the alleged victim that the involved staff was "trying to get them to beat [the victim] up." Neither victim chose to report these threats and intimidation to the facility administration, nor did they want their concerns to be reported at the conclusion of the interviews with my colleagues. Although the veracity of these allegations cannot be confirmed without the victims' cooperation, it is worth reminding staff that they are prohibited from threatening, intimidating or otherwise discussing the substance of matters under investigation with youth.
Recommendations	It is recommended that the State: 1. Train all facility staff responsible for conducting investigations of the issues listed in this Provision. 2. Ensure that investigations produced by facility staff meet generally accepted practices for the investigation of employee misconduct and youth mistreatment. 3. Provide feedback to youth about the status of investigations triggered by a grievance or other report of staff mistreatment. As personnel regulations allow, inform youth of the outcome of the investigation once it is completed. (see discussion in Provision D.1, below).
Sources of Information	▪ Self-Assessment materials for Provision 5, prepared at my request ▪ Follow-up telephone conversations with the facility administrator who oversees the investigations

III.A.6 Staff Training in Behavior Management, De-Escalation and Crisis Intervention. The facilities shall train all staff in behavior management, de-escalation techniques, appropriate communication with youth and crisis intervention before staff may work in direct contact with youth.	
Self Assessment	Detailed training records revealed that the facility's training efforts remain comprehensive and exceed generally accepted practices in this area. Across the eight new staff who began working in the past three months, all completed the new employee training sessions required by this provision. A total of 24 separate training courses were required for veteran staff in 2010. Across the 286 veteran staff, 92% completed all 24 training courses. Completion rates for individual courses ranged from 64% to 98% (the course with the 64% completion rate was added to the training requirements at the end of 2010). The average rate of completion across courses was 92%.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The facility's policies, procedures and practices related to staff training appear to meet the requirements of this provision.
Sources of Information	▪ Self-Assessment materials for Provision 6, prepared at my request

III.A.7 Employment Practices. The State shall use reasonable measures, including background checks and criminal records checks, to determine applicants' fitness to work in a juvenile facility prior to hiring employees for positions at the facility.	
Self Assessment	In the past three months, the facility hired four new employees. All of these passed the background check and did not have criminal records for any of the offenses that would bar their employment according to State personnel regulations. One staff was slated for employment but ultimately not hired because he did not pass the drug test.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The facility's policies, procedures and practices related to employment practices appear to meet the requirements of this provision.
Sources of Information	• Self-Assessment materials for Provision 7, prepared at my request

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.	
Self Assessment	As discussed in my previous report, the grievance process at Scioto addresses all of the components required by this provision: no preconditions, review by the chief inspector, timely initiation and resolution, appropriate corrective action, and written notification to youth of the final resolution. Between November 2010 and January 2011, 106 grievances were submitted. All were resolved within the 14 days permitted by policy. The number of grievances submitted was comparable to previous periods of review, although the timeliness has improved. All of the grievances were reviewed by the CIO, which requested additional follow-up in 15% of the cases. The CIO oversight is a solid mechanism for ensuring the quality of the response.
Steps Taken to Assess Compliance	Copies of the 106 handwritten grievances were submitted for my review. The responses to the grievances were timely and showed persistent efforts to understand the problem presented by the youth and to identify a fair and reasonable resolution. My colleagues on site (DOJ attorneys and Dr. Daphne Glindmeyer) heard concerns about the grievance process that echoed the concerns discussed in my previous report (see DOJ's letter dated March 11, 2011, pages 3 and 4). Although I did not have the opportunity to talk to the youth myself, my sense is that locating their concerns within the grievance process could inadvertently misdirect the efforts toward solving the problem. Youth continue to be satisfied with the grievance process insofar as it addresses typical quality of life issues (e.g., clothing, behavior management decisions, food, disciplinary issues, etc.). Their dissatisfaction appears to be centered on the facility's response to more serious complaints about staff mistreatment. Although the youth may voice the complaint using the grievance process, complaints of this type are always referred for investigation—they are not handled by the Grievance Coordinator. Labeling the concern as one about the grievance process is misleading; really, it is the investigations into staff misconduct or mistreatment with which the youth take issue. Discussions with facility administrators during the teleconference on February 25, 2011 included a discussion about this issue and the steps that the facility could take to ameliorate the youths' concerns.
Recommendations	The facility's procedures and practices related to the grievance system address all of the requirements of this provision. (Please see Recommendation #3 under Provision 5 that addresses the concern discussed above).
Sources of Information	• Self-Assessment materials for Provision D.1, prepared at my request • Follow-up telephone conversations with the Grievance Coordinator • Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

III.D.2 Grievance 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.	
Self Assessment	The facility audited intake files for youth admitted in November and December 2010 and January 2011. Ten percent of the youth admitted during this time period were included in the sample (n=21 youth). The audit found that 100% of these youth received a complete orientation to the facility, which included information about how to access the grievance system.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's policies, procedures and practices related to explaining the grievance system to youth appear to meet the requirements of this provision.
Sources of Information	• Self-Assessment materials for Provision D.2, prepared at my request

III.D.3 Grievance Process. Without any staff involvement, youth shall easily be able to obtain grievance forms and submit grievances.	
Self Assessment	In my previous report, I noted that there are 19 grievance boxes throughout the Scioto campus, in each building where youth congregate. Grievance forms are stocked right next to each box. Youth are required to seek permission to use a pencil, but the Grievance Coordinator reported that she has never received a complaint from youth that they were denied permission. Further, in staff meetings, staff are consistently reminded that they are prohibited from impeding the grievance process in any way. No additional self-assessment was requested on this issue.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's policies, procedures and practices related to youth accessing the grievance system appear to meet the requirements of this provision.
Sources of Information	• No new information was collected or reviewed related to this provision.

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 poses an immediate risk of harm to self or others; c) following an adequate disciplinary hearing, pursuant to an appropriate disciplinary sanction. 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.	
Self Assessment	As discussed in my previous reports, the facility has brought a wide array of programs to the facility, relying heavily on the contributions of community volunteers and those from various faith-based organizations. Most recently, the facility reported its intention to create a Youth Activity Tracking System (YATS) to track individual-level program participation data. The YATS will also permit the facility to aggregate these data to look at facility-wide trends. These data will be helpful to the facility's efforts to minimize idle time, to ensure equal access to programming across units, to identify the types of programs that are of greatest interest to youth, and to hold Unit Managers and Youth Specialists accountable for following the unit schedules. My colleagues on site (DOJ Attorneys and Dr. Daphne Glindmeyer) heard several complaints from youth on the reception units that staff sometimes did not provide sufficient notice of the programs available to them (see DOJ's letter dated March 11, 2011, page 6). They complained of excessive idle time on the weekends, in particular. Once implemented, the YATS should be used to discern whether programming opportunities on these units should be expanded and whether staff are following the proper procedures to ensure youth's access to them. Approximately 10% of the facility's youth currently hold paid work positions at the facility (e.g., office assistant, storeroom, hairstylist, cosmetology assistant, cafeteria workers, recreation assistants, and school tutors). During the teleconference held on February 25, 2011, facility staff reported that two committees have been activated to increase the number of jobs available to Scioto youth. Their goal is to create sufficient job positions so that all youth holding a GED or diploma will have access to meaningful vocational opportunities. While employment opportunities are not specifically required by this provision, the effort to minimize the amount of unstructured time these youth experience throughout the school day is certainly relevant to the State's efforts to comply with the requirements of this provision. The Strength Based Behavior Management System (SBBMS) continues to experience the typical growing pains that accompany the implementation of behavior management programs. In my last report, I noted that the majority of the program appeared to have been properly implemented, but that the facility

	was struggling to ensure that staff completed the Character Coupons that serve as intermediate reinforcers of positive behavior. The self-assessment information indicated that the implementation difficulties are located primarily in the Reception units, where the SBBMS program was most recently implemented. In addition to having less experience with this system, staff on these units are also not as program oriented as staff on the long-term units. An individual from DYS' headquarters is in the process of developing a training to increase staff skill in using the Character Coupons. The oversight (i.e., review of Character Coupon distribution in the weekly meetings) and on-going training provided to support the full implementation are both essential to this task. Problems with the SBBMS on the Reception units were echoed in the interviews conducted by my colleagues on site (see DOJ's letter dated March 11, 2011, page 6). In addition to complaints about the lack of available programs, youth on the Reception units felt that the SBBMS was of limited value given the restricted range of incentives available to them. Youth complained that the only options available were an extra envelope for writing letters, the use of a board game, or a later bed time, and that these options were not particularly compelling. Further, their descriptions of the use of intermediate sanctions (e.g., early bed time (EBT), writing assignments) are of concern. Youth indicated that some staff imposed EBT as group punishment in response to a small group of youth acting out and that EBT was sometimes excessive (was imposed during the late afternoon or early evening). Other youth reported that they were required to given assignments to copy parts of the dictionary or to write and rewrite a set of rules. These assignments often took hours to complete and were judged to have no value. Although it is appropriate for staff to impose sanctions for minor misconduct, they should be encouraged to impose assignments that have some connection to the behavior itself (e.g., an apology letter to a staff the youth treated disrespectfully; an essay about why proper line movement is important; etc.). Assignments that simply consume time without any substantive message are not effective behavior management tools. Given these concerns, and those related to the newness of the SBBMS in the Reception units, it is recommended that the facility undertake an inquiry into the way in which intermediate sanctions are imposed to ensure that they are fairly and consistently implemented by staff, and to ensure that they are both relevant and proportional to the youth's misconduct.
Steps Taken to Assess Compliance	As discussed in my previous report, this provision requires the State to provide access to programming required for parole eligibility. To investigate this issue, I reviewed the ReEntry Plans and case notes for 20 youth who were housed at Scioto during my last visit. Most of the parole requirements were generic and were fulfilled by programs that all youth now have access to at Scioto: following rules and developing social skills and decision making skills (via the SBBMS); attending school (youth attend school); and identifying pro-social leisure time activities (youth have access to recreation and a variety of other programs). While there may be improvements to be made in each area to solidify these opportunities, for the most part, these programs target the issues of concern to the Release Authority. Other parole requirements pertained to treatment-

	related issues and are addressed by Dr. Glindmeyer's review of the mental health program at Scioto.
Recommendations	To reach substantial compliance with this provision, the State should: 1. Ensure adequate programming opportunities are available to all youth at the facility, particularly those on the Reception units. 2. Fully implement the SBBMS across all units, particularly the use of Character Coupons. 3. Examine the imposition of intermediate sanctions by staff to ensure they are both relevant and proportional to the type of misconduct exhibited by youth.
Sources of Information	▪ Self-Assessment materials for Provision F.1, prepared at my request ▪ Follow-up telephone conversations with the facility administrator who oversees programming ▪ Consultation with DOJ Attorneys and Dr. Daphne Glindmeyer

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 the facility's 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.	
Self Assessment	The facility audited intake files for youth admitted in November and December 2010 and January 2011. Ten percent of the youth admitted during this time period were included in the sample (n=21 youth). The audit found that 100% of these youth received a complete orientation to the facility, which included, among other things: • Youth Handbook • Orientation Video • Facility rules and consequences (IRAV) • Obtaining legal assistance • Sexual abuse and sexual assault information • Grievance system The Youth Handbook was updated again in October 2010 to provide accurate information to youth about security classification procedures and unit descriptions, IRAV, and SBBMS. That the handbook is keeping pace with most of the changes to Scioto's programming is very positive. However, as noted in the DOJ's previous compliance report, the Handbook does not adequately describe the youth's rights related to practicing their religion of choice, particularly how they may seek accommodations for religious beliefs, practices or observance as described SOP #507.02.06.
Steps Taken to Assess Compliance	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The facility's orientation process appears to meet the requirements of this provision.
Sources of Information	• Self-Assessment materials for Provision F.2, prepared at my request

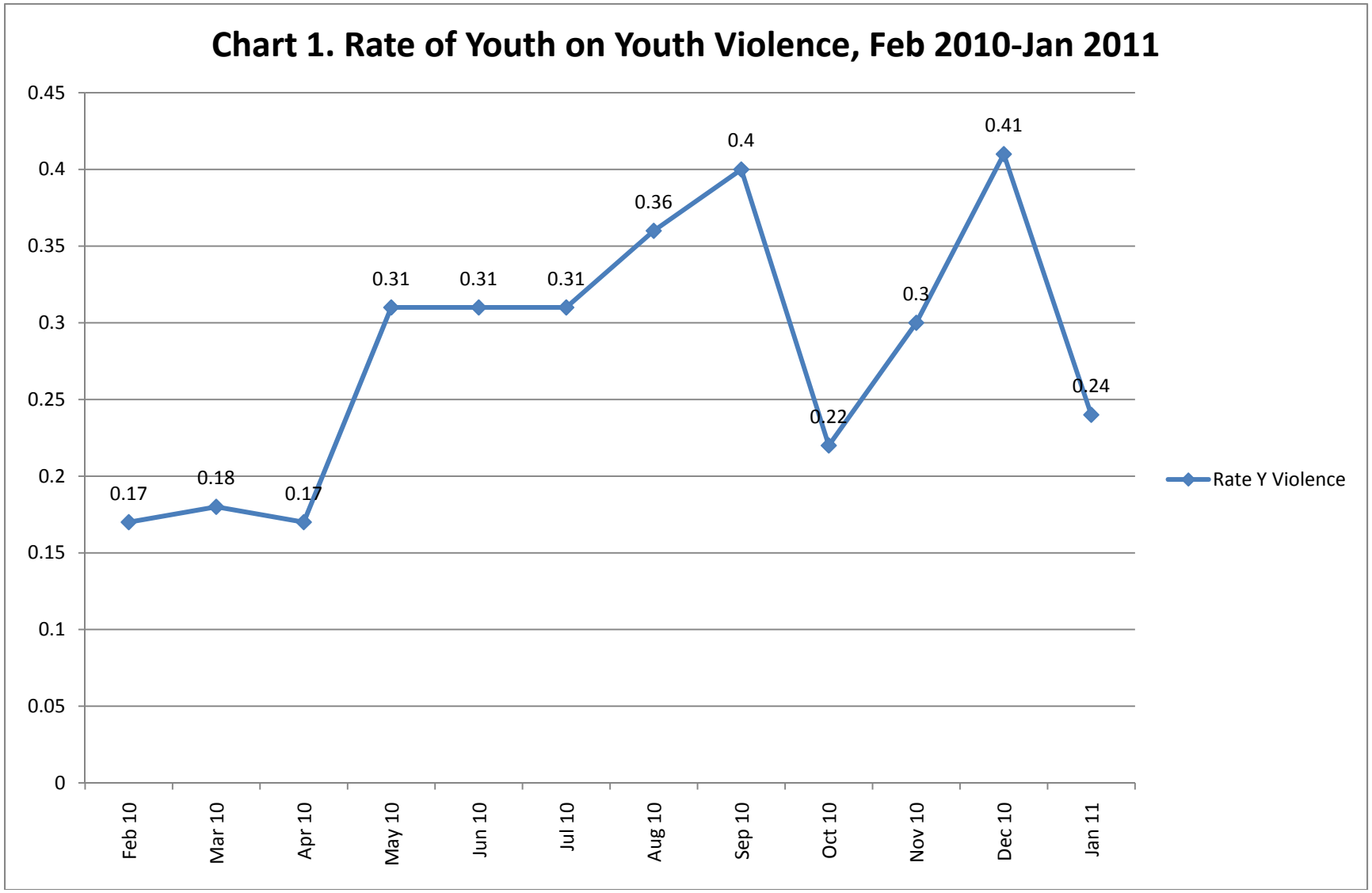
Chart 1. Rate of Youth on Youth Violence, Feb 2010-Jan 2011
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
0.17
0.18
0.17
0.31
0.31
0.31
0.36
0.4
0.22
0.3
0.41
0.24
Feb 10
Mar 10
Apr 10
May 10
Jun 10
Jul 10
Aug 10
Sep 10
Oct 10
Nov 10
Dec 10
Jan 11
Rate Y Violence

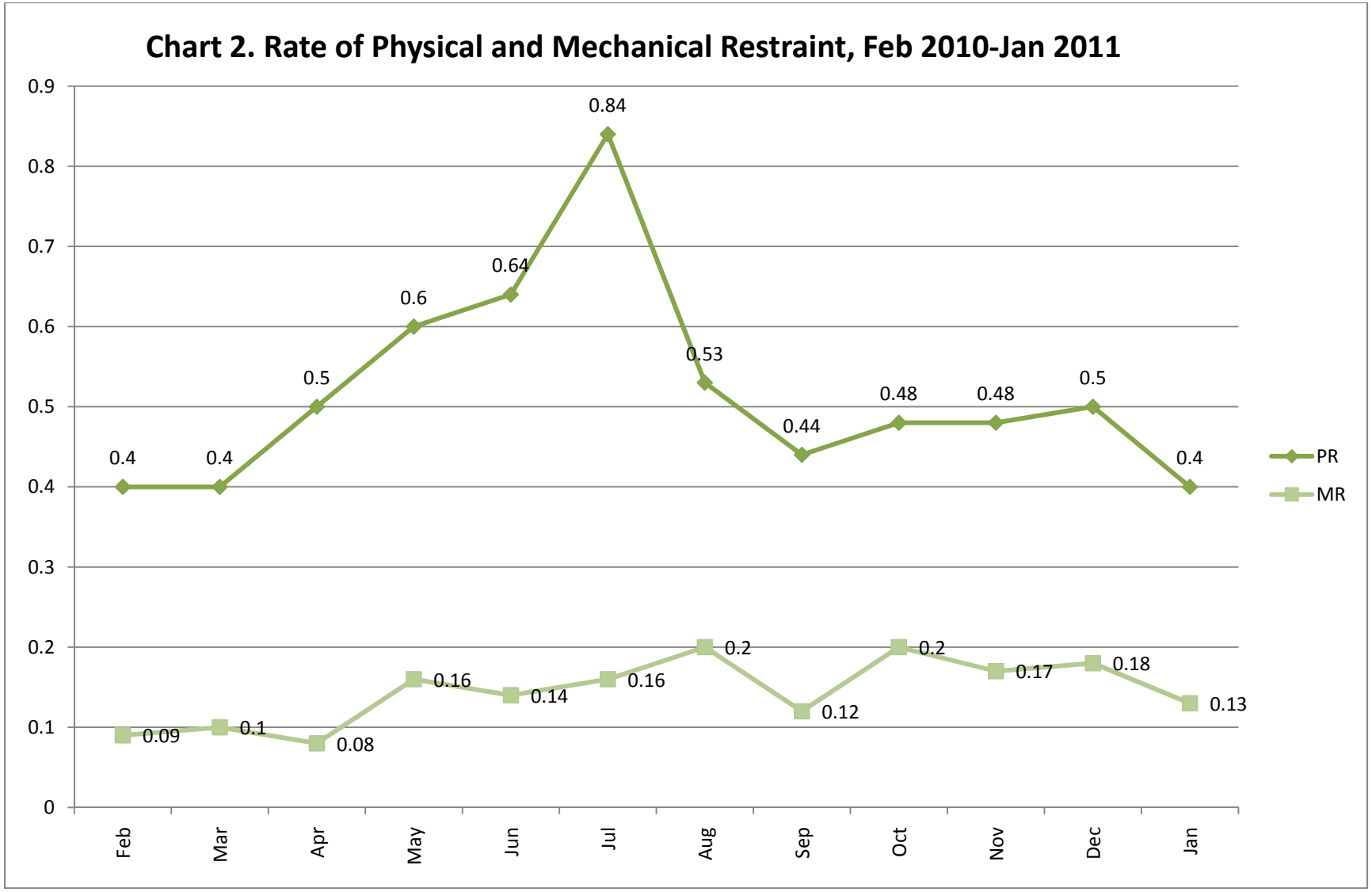
Chart 2. Rate of Physical and Mechanical Restraint, Feb 2010-Jan 2011
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.4
0.4
0.5
0.6
0.64
0.84
0.53
0.44
0.48
0.48
0.5
0.4
0.09
0.1
0.08
0.16
0.14
0.16
0.2
0.12
0.2
0.17
0.18
0.13
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
PR
MR

Attachment B

U.S. Department of Justice v. The State of Ohio
Civil Action No: 2:08-cv-475

2nd Special Education Compliance Report

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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). The Stipulation adopted the same monitoring team used in a concurrent suit, *S.H. et al., v. Tom Stickrath (S.H.)*, led by Fred Cohen, Esq. This team was charged with monitoring the extent to which the State had effectively implemented the reforms required by the Stipulation and providing detailed reports to the Parties. Since the Stipulation was signed, the State closed the Marion facility.

In late 2009, Mr. Cohen announced his intention to resign his position as the Monitor for the Stipulation, while continuing his duties as the lead monitor in *S.H.* On November 23, 2009, the Parties amended the Stipulation to assigning monitoring duties for Scioto to the DOJ. Both Parties agreed that I, Dr. Kelly Dedel, would serve as the DOJ's expert for protection from harm and special education issues.

This is my 2nd report on the special education program at Scioto. The DOJ opted for my assessment to be conducted remotely, and thus, while the State provided a large volume of useful information, I was limited in the extent to which I could verify the State's data or delve further into certain issues. This report draws on the State's self-assessment materials submitted in late February 2011 and a series of follow-up telephone calls and emails with various Scioto and DYS staff. For the sake of brevity, I have not reiterated information from previous reports that testified to the State's compliance with each provision (e.g., discussions of policy and procedure; data analysis from previous monitoring periods; etc.). The reader is encouraged to read my 1st Compliance Report for a complete discussion of these issues.

In March, 2011, the Ohio Legislature indicated its intention to close the Ohio River Valley (ORV) facility. The closure of this facility and the subsequent transfer of youth to other facilities in the State will have a significant impact on Scioto's ability to sustain its progress in making the required reforms. The transfer of youth must be carefully planned and managed so that the negative outcomes experienced during the closure of other DYS facilities may be avoided. The State is encouraged to share its plans for the transfer of youth to Scioto and how its previous experiences with facility closures will inform the upcoming reassignment of youth and redeployment of staff.

Section V.H of the Stipulation requires the Monitor/expert to provide the Parties with reports "describing the steps taken by the State to implement [the] Stipulation and to evaluate the extent to which the State has complied with each substantive provision of the Stipulation." This is my second report on the 11 provisions related to the special education program at Scioto. The DOJ opted for my assessment to be conducted remotely, and thus, while the State provided a large volume of useful information, I was limited in the extent to which I could verify the data presented by the State or further delve into key issues. This report draws on the State's self-assessment materials submitted in late February 2011 and a series of follow-up telephone calls to various DYS and Scioto staff. For the sake of brevity, I have not reiterated information from previous reports that testified to the State's compliance with each provision (e.g., discussions of policy and procedure; analysis from previous monitoring periods, etc.). While I attempted to verify sustained compliance in areas which were found to be in good order during my last review, the most substantive discussions here are reserved for those areas in which I still have concerns.

This report describes the status of the facility with regard to the reforms required by the Stipulation. For each provision, the full text is provided, along with a detailed discussion of the State's compliance as required by the Stipulation. The specific language from the Stipulation is presented in *italics* below, along with my interpretation of it.

- *"The self-assessment steps the facility undertook to assess compliance and the results thereof*." In response to a detailed document request I crafted to focus on specific performance measures for each provision, the State presented a large volume of information and data to demonstrate its progress in meeting the requirements of the Stipulation to date. This information is summarized.

- *"[My own] steps taken to assess compliance*." Because I did not travel to Scioto, I did not take any independent actions to assess compliance, other than to ask clarifying questions about the State's self-assessment or to analyze the data contained in it.

- "*Recommendations for facilitating or sustaining compliance*." These recommendations are generally outcome-focused so as to reinforce the spirit of the provision itself, but also to permit the State sufficient flexibility to satisfy both this Stipulation and the requirements of *S.H.* The recommendations in this section are limited to those needed to demonstrate substantial compliance with the provision.
- *"Sources of information that form the basis of [my] opinion*." The self-assessment documents were organized by provision, and are referenced accordingly.

Given that the DOJ has been appointed as the Monitor in this case, I have not offered specific compliance ratings for each of the provisions. Instead, I endeavored to describe the current state of affairs in each area, along with my assessment of the steps needed for the State to meet the requirements of the provision.

Provision 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 promulgate there under, and this Stipulation.	
Self Assessment	One of the main concerns discussed in my 1st compliance report was the extent to which youth in the various forms of disciplinary isolation were permitted access to the education program. In its self-assessment, the State reported that of the 10 youth who were held in isolation for more than 24 hours (on a school day) in November and December 2010 and January 2011, only one of them (10%) received access to instruction or educational materials. In a follow-up conference call, the State reported that the other nine youth were in isolation for less than 10 days, and by ODYS policy, the State was not required to provide education services. The Court ruled on this matter in late March, 2011, requiring the State to develop policies and procedures for Alternative Education Opportunities (AEO) for youth in seclusion. While the details still need to be fleshed out, in general, the State is now required to provide education services to youth as soon as possible after the onset of seclusion (rather than the 10-day threshold in use since June 2010). The AEO procedures flowing from the Court's order and the implementation of those procedures require continued monitoring under the Stipulation to ensure the requirements of this provision are met. The second concern addressed in my previous report was the extent to which teachers were skilled in behavior management techniques that could prevent excessive or unnecessary exclusions from the classroom. Since the previous compliance tour, Dr. Yurick, a DYS consultant, held two training sessions on the use of the Strength Based Behavior Management System (SBBMS) in the classroom. My review of documents suggested the training curriculum was high quality and that most of the Scioto education staff attended. Education administrators reported that teachers have begun to use the Character Coupons more consistently. Further, administrators' reported that their classroom observations and reviews of lesson plans suggested that teachers were better engaging students throughout the class periods. The State also provided data on the use of its in-school suspension program, the ABC Room. Over a three month period, 61 girls were sent to the ABC room and 90% of them were de-escalated sufficiently to return to school during the following class period. Among the boys, 296 were sent to the ABC room and 91% returned to class. Thus, it appears that the teachers at Scioto are utilizing the variety of skills needed to manage student behavior constructively and to maximize the students' engagement in the education program.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	To meet the requirements of this provision, it is suggested that the State: 1. Provide regular, dependable access to class assignments and instruction by certified teachers to youth in the various forms of disciplinary isolation. 2. Reach substantial compliance with the remaining provisions in the special education section of the Stipulation.

Evidentiary Basis	▪ Self-Assessment materials for Provision 1, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal. ▪ *S.H. Order #249*, filed March 28, 2011

Provision 2. Oversight. The State shall provide adequate oversight of special education at the facilities.	
Self Assessment	Over the past three months, the Special Education Director reviewed a total of 19 special education files and provided guidance on formulating measurable annual goals and clarifying the types of services to be provided so that the documents were internally consistent. Further, the Director regularly communicated with Scioto education staff by telephone and email and held individual and group sessions with special education teachers on these same topics. Statewide meetings were held with the facility Special Education Administrators and the Special Education Secretaries.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The oversight provided by the DYS Director of Special Education appears to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 2, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 3. Special Education Upon Intake. The State shall ensure that all students who qualify for special education services receive such services within a reasonable time following intake at the facilities.	
Self Assessment	The State reported that all 215 students (100%) admitted to Scioto over the past three months received an education intake interview, records request, education program plan, and educational screening within 72 hours of their admission. The purpose of these activities is to ascertain the student's performance level, appropriate grade placement and special education status. All students (100%) were enrolled in school on the 4th school day following their admission. Of the 13 girls admitted over the past three months, three (23%) were identified as special education students upon entry. Of the 202 boys admitted, 83 (41%) were identified as special education students upon entry. The students' schedules were constructed using the most recent data available at the time of admission. Once records from previous schools were collected, adjustments were made as necessary to ensure compatibility with the IEP. Given Scioto's function as a reception center, the schedule construction process appears to be reasonable. With the planned closing of ORV, Scioto will likely receive additional students in its long-term programs. Schedule development for these students is generally more straightforward, because the record retrieval and assessment processes are complete for these students. Further, the proportion of students who are identified as special education students reflects contemporary research that estimates that between 20 and 60 percent of incarcerated youth are eligible for special education.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's procedures and practices appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 3, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 4. Parent or Guardian Involvement. The State shall develop and implement policies, procedures and practices to appropriately notify and involve parents or guardians in the provision of special education services, whenever possible.	
Self Assessment	The State reported that parent packets were mailed in a timely manner for two of the three special education students admitted to Scioto's long-term programs over the last three months. The other student was not initially identified as a special education student because of a data entry error, resulting in a delay in initiating the surrogate parent procedures needed for this youth. This is not a systemic problem. Parents regularly attend IEP meetings, usually by teleconference. The State reported low rates of compliance across the last three IEP progress reporting periods. These concerns are addressed in Provision 7, Individual Education Plans. Given the State's track record of regularly informing parents of the steps to be taken to update their children's IEPs and providing multiple opportunities for their participation, the procedures and practices in this area appear to conform to the requirements of this provision.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's procedures and practices appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 4, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 5. Staffing. The State shall develop and implement an education staffing plan to ensure adequate staff to comply with the terms of this Stipulation.	
Self Assessment	The staffing plan remains unchanged from my previous report and appears to be adequate to meet the needs of both short- and long-term students at Scioto. If the facility receives a significant number of students as a result of ORV's closure, the State will need to revisit its staffing plan, using a similar methodology as that used to create the original one. As discussed in my previous report, there were two key vacancies in the education staff: a Transition Skills teacher and a Speech Language Pathologist (SLP). While the Transition Skills teacher has not yet been hired at the time of my teleconference in mid-February 2011, Scioto administrators reported that final approvals had been received to hire the individual identified for this position, and should be imminent. After multiple unsuccessful efforts to attract a qualified SLP, DYS decided to provide these services via a contractor who provides SLP services at another DYS facility. The contract for these services has reportedly been signed and approved. For the past three months, Scioto has not housed any students requiring SLP services as part of their IEPs, and thus it is highly unlikely that the vacancy has negatively impacted the State's ability to comply with the requirements of the Stipulation. In January 2011, one of the facility's English teachers resigned. Efforts to recruit for this position have begun. Students originally scheduled into this teacher's class have been rescheduled into other English sessions. The small class sizes at Scioto allow for this redistribution without compromising the quality of services provided to students. As stated in my previous report, all facilities experience some level of teacher turnover. At Scioto, turnover does not appear to be excessive and efforts to fill vacant positions are clear. The fact that Scioto has two Transition Skills teaching positions, one of which has been filled consistently throughout the past year, limits the negative impact of the one persistent vacancy. Nevertheless, given Scioto's current number of students, and potential increase in number of student's with ORV's closure, the State is encouraged to fill this vacancy as soon as possible.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's staffing plan and its efforts to staff the facility accordingly appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 5, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 6. Screening for Special Education Needs. (a) The State shall provide prompt and adequate screening of youth for special education needs and shall identify youth who, upon admission to the Ohio Department of Youth Services, were receiving special education in their home school districts or who may be eligible to receive special education services but have not been so identified in the past. (b) The State shall ensure that those staff conducting the screening, assessment and evaluation processes are qualified to do so.	
Self Assessment	A total of 215 students were admitted to Scioto over the past three months. Via the intake process described in Provision 3, above, 86 students (40%) were identified as special education students. Among the remaining regular education students, 96 students' (85%) intake records revealed discrepancies between the students' level of performance and grade levels. Because students are tested so quickly upon admission (when they may be anxious, disengaged or otherwise not performing at their best), the test scores often underestimate students' true abilities. During the first few weeks the student is in class, teachers begin to implement various interventions in their own classrooms to better understand any performance deficits and to identify ways to address them. If the academic troubles are confirmed and the teacher cannot identify ways to address them, he or she may be referred to the IAT (Intervention Assistance Team). Two students were referred to the IAT in the past three months. One student was tested but determined not to be eligible for special education; he receives on-going IAT support. The other student was transferred to another DYS facility, along with his IAT records.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's intake practices and IAT resources appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 6, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 7. Individual Education Plans. (a) The State shall develop and 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.	
Self Assessment	A total of 72 special education students were admitted to Scioto between November 2010 and February 2011. To date, only three of these were admitted to one of Scioto's long-term programs (others may ultimately be housed at Scioto, but their admissions were too recent to know as of the writing of this report). All three students' eligibility documents (e.g. the Evaluation Team Report, ETR) were updated if needed and their IEPs were adopted, revised or updated in a timely manner. Of the 11 long-term Scioto students whose IEPs were updated in the past three months, all IEP meetings (100%) included the required participants. Although about 40% of the IEPs required some level of correction to ensure compliance with recently updated State guidelines, all but one or two were judged to be at least minimally compliant when reviewed by either the Special Education Director or Scioto Administrator. Historical problems with the articulation of clear, measurable IEP goals have persisted, but the facility's process for reviewing draft IEP language *before* the IEP meeting ensures that well-articulated goals are formalized at the IEP meeting. The 23 special education students who were housed at Scioto on January 21, 2011 were served in a variety of ways—consultation between special and regular education teachers; provided with special education services while in the regular classroom; or provided with special education services within a special education classroom. Ten of the students received related services from an Occupational Therapist. Taken together, it appears that Scioto has the resources and flexibility to meet the diversity of students' special education needs. As discussed in Provision 4, above, the level of compliance with sending reports of students' progress in meeting IEP goals to parents is not what it should be. The State reported compliance rates of only 22% in July 2010; 30% in October 2010; and 9% in January 2011. While teachers' failure to place a copy of the mailed progress report in the students' files may make the problem appear worse than it is, the large proportion of files that were not in compliance is of great concern. This finding triggered two corrective actions by DYS: 1) to require all progress

	reports to be scanned into OPTIX, thereby eliminating the need for a paper copy to be placed in the file; 2) to require all teachers to submit drafts of student progress reports to Scioto's Special Education Administrator in advance of the due date, who reviews them to ensure that the reports are completed and to assure that they include specific indicators of student progress (i.e., not simply "student making adequate progress"). Progress reports are due again in late March and late June 2011—hopefully these measures will result in higher rates of compliance. The overall objective for crafting IEPs, articulating measurable goals and periodically measuring improvement is to ensure that students actually acquire the skills they need to make academic progress. The progress reports thus provide some measure of how well a given facility is accomplishing that objective. Success in meeting IEP goals was assessed for a sample of 10 students who had been housed at Scioto for at least 1 year (the term of an IEP) and whose IEPs had been written at Scioto or another DYS facility (to ensure consistent quality). Most of these students had multiple IEP goals. Across the 26 total goals, only 45% were rated as "met" during the students' annual reviews. Given these results, it is suggested that Scioto review these 10 students in more depth to determine why they were unable to achieve the goals set out for them (i.e., something about the way the goal was written? Something about the type of instruction provided? An inability to engage the student in the program?). Only with this type of critical analysis can the overall quality of the education program at Scioto be improved.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	In order to meet the requirements of this provision, it is suggested that the State: 1. Increase teachers' skills and compliance in monitoring and reporting student progress to ensure the extent to which the IEP actually resulted in improved student outcomes can be assessed.
Evidentiary Basis	▪ Self-Assessment materials for Provision 4 and 7, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 8. Vocational Education. The State shall provide appropriate vocational services that are required transition services for disabled youth under the IDEA.	
Self Assessment	The vocational services available to students at Scioto continue to be limited to a single career technology class, Administrative Office Technology (AOT). This course includes instruction in the Microsoft Office programs and is available to both girls and long-term male residents who may earn of a certificate of course completion. On January 31, 2011, 16% of the long-term boys were enrolled in AOT, along with 22% of the girls. Given that Scioto is likely to be many students' final secondary school placement, providing access to a broader range of vocational options for students is essential. The State's proposal to bring short-term vocational options to Scioto discussed in my previous report has been withdrawn due to personnel and logistical barriers. Instead, the DYS Superintendent proposes dividing the AOT program into specific modules so that certificates in each program can be earned; adding work-study opportunities; and introducing job skills into certain academic classes. The specific opportunities and projected capacity for these programs is unknown at this time.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	In order to meet the requirements of this provision, it is suggested that the State: 1. Develop additional vocational opportunities for students that are realistic based on the short lengths of stay for most students and the employment opportunities likely to be available in their local communities.
Evidentiary Basis	▪ Self-Assessment materials for Provision 8, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 9. Forwarding Screening and Assessment Information Upon Transfer. The State shall ensure that, when a youth is discharged from the facilities before the interventions required in Section III.E.6 above are complete, the facilities shall forward to the superintendent of the youth's receiving school district all information regarding screening and evaluations completed to date, noting what evaluations are yet to be performed.	
Self Assessment	The State reported that over the past three months, six students were referred for either initial testing to determine special education eligibility or reevaluations to confirm their continued eligibility but were released from Scioto prior to the testing process being completed. In all cases, the State reported their records were forwarded to the students' receiving school districts.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's procedures and practices appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 9, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 10. Training and Quality Assurance. The State shall design and implement adequate annual training requirements for special education staff.	
Self Assessment	The State provided data on the education staff's attendance at various professional development sessions throughout 2010. Of the 31 total education staff, 30 (97%) received at least 15 days of professional development in the past year. Further, coaching by the DYS Special Education Director and Scioto Special Education Administrator provided additional skill-building opportunities for teachers in IEP development and monitoring student progress.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	The State's practices with regard to professional development appear to meet the requirements of this provision.
Evidentiary Basis	▪ Self-Assessment materials for Provision 10, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Provision 11. Transition Services. The State shall comply with any IDEA requirements for providing transition assistance. The State shall provide transition assistance to students by providing counseling and concrete information regarding appropriate community resources and how to pursue post-secondary options, re-enroll in school or complete the GED.	
Self Assessment	On January 31, 2011, 44 of Scioto's 95 boys (46%) were participating in the Transition Skills program. Filling the second Transition Skills position (as discussed in Provision 5, above) will allow Scioto to enroll students in all of Scioto's programs in this important transition course. Over the past three months, 13 youth were released from Scioto's long-term programs. Of these, the State reported that the Transition Coordinator worked with 12 of them (92%). For some students, the Transition Coordinator facilitates re-enrollment in school upon release, while for other students, linkages are made with community resources that can facilitate job placement.
Discussion	As discussed in the Introduction to this report, I did not conduct any on-site inquiries.
Recommendations	In order to fully meet the requirements of this provision, it is suggested that the State: 1. Fill the vacant Transition Skills instructor position to ensure all students have access to this service.
Evidentiary Basis	▪ Self-Assessment materials for Provision 11, prepared at my request ▪ Follow-up consultation via teleconference with DYS Superintendent, Assistant Superintendent, Special Education Director, Scioto Principal, and Scioto Assistant Principal.

Attachment C

United States of America v. The State of Ohio
Case No. 2:08-cv-475

Review of the Scioto Juvenile Correctional Center Mental Health Services

Dr. Daphne Glindmeyer

April 13, 2011

Dr. Daphne Glindmeyer is a board-certified psychiatrist with more than 14 years of experience treating youth and adults in correctional settings. She received her Medical Degree from the Louisiana State University Health Services Center in New Orleans and is board-certified as an adult psychiatrist, forensic psychiatrist and child and adolescent psychiatrist.

Her clinical background includes extensive work with juvenile offenders. This includes her work as a clinical psychiatrist at the Bridge City Center for Youth, a secure juvenile facility in Louisiana, and past work with the Louisiana State University Health Sciences Center Juvenile Corrections Program, where she served as the Director of Psychiatry and the Director of Clinical Operations, and with the Jefferson Parish Juvenile Drug Court Program, where she served as the Medical Director.

She has also provided compliance monitoring regarding mental health and rehabilitative services for several jurisdictions — including monitoring in Mississippi regarding its secure juvenile correctional facilities, in Los Angeles County regarding its secure juvenile correctional facilities, in Texas regarding five developmental centers in the state, and in Indiana regarding the South Bend Juvenile Correctional Center.

Dr. Glindmeyer is a fellow of the American Psychiatric Association, the current president of the Louisiana Council of Child and Adolescent Psychiatry, and a past president of the Louisiana Psychiatric Medical Association.

1.	**<u>Mental Health Screening</u>: 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, aspart of the intake process, consistent with generally accepted professional standards of care.**
Discussion	Per facility policy and procedure entitled, "Mental Health Screenings", a mental health screening is to be performed within 24 hours of admission by mental health trained or qualified mental health personnel to assess presence of current suicidal ideation, history of self injurious behavior, current prescription of psychotropic medication, current mental health issues, current treatment for mental health diagnoses, history of any type of mental health treatment and history of substance abuse. Review of youth records available for off site review revealed variability in the documentation created as a result of the intake assessment process. This was an issue that will be discussed in several ensuing provisions. Per the facility verbal self-assessment, there were plans for a new Behavioral Health Appraisal document. This had not been implemented at the time of the tour, but was planned for testing the week following the tour, with plans to fully implement the format as of 3.15.11. It was reported by administrative staff that this document would provide improved case conceptualization and diagnostic clarification with recommendations for treatment. A review of documentation generated as a result of the full implementation of policy and procedure governing this entitled "Behavioral Health Assessment, Screening, Appraisal and Evaluation" will be requested in future record review.
Recommendations	. Full implementation of policy and procedure "Behavioral Health Assessment, Screening, Appraisal and Evaluation." . Begin quality assurance monitoring or clinical supervision regarding the reception assessment summary documents.
Evidentiary Basis	. Review of provided documents (e.g. policy and procedure, draft policy and procedure, youth records). . Staff interview

2.	**<u>Immediate Referral to a Qualified Mental Health Professional</u>: 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.**
Discussion	Per the facility verbal self-assessment and a review of policy and procedure, the Policy and Procedure entitled, "Referrals to Mental Health Services" delineates the referral process for youth to access mental health services, stating, "referral can take place in reception or on a programming unit, and is made via the psychology supervisor. When a youth has expressed suicidal or self-injurious thoughts, intent or plans, or when a unit staff member develops concerns for a youth's functioning on the unit, referral for an assessment can be immediate by phone with the psychology staff assigned to the relevant living unit or by email... In the event that psychology staff are not available on grounds, Operations staff are notified and they call the psychology supervisor by phone and discuss the concerns." Per staff interview, the psychology supervisor is on continuous call. A review of the psychology staff schedule revealed that psychology staff are assigned both evening and weekend hours to provide youth access to services. The extended hours allowed youth increased opportunities to access mental health staff, and were a positive finding during the tour. Per discussion with facility administrative staff and a review of Ohio Rev. Code Sec. 4757.02(A)(5), civil servants in Ohio are exempted in that they do not have to have licensure to perform as a social worker, thus unlicensed staff would qualify as a QMHP in this system. The designation of unlicensed staff as a QMRP was a novel situation for me, and bears consideration. The use of unlicensed staff is not consistent with generally accepted practices. Regardless, utilizing the current staffing model and QMRP designations, when combined for both disciplines, social work and psychology, there would be a QMRP on campus from 8 am to 8 pm Monday through Friday, and from 9 am to 5 pm on weekends. Review of provided documentation regarding the referral and ultimate assessment of a youth by mental health staff revealed that with regard to capacity assessments, 26 youth were assessed between 11.11.10 and 2.11.11. Of these all were done one the same date as the request except one, where the request was made 11.30.10 and the assessment was

	completed 12.2.10. There was documentation of four youth mental health requests (made per the youth themselves), all seen within four hours of request. There were 32 youth referred for risk assessment at intake, all documented as having been seen on the day of request, however, the time of the request and assessment was not noted, so it was not possible to determine if this was performed within the four hour time requirement. These statistics do not take into account referrals for mental health intervention that are performed at the request of facility mental health staff. As stated during the facility verbal self-assessment, youth were not documented as making frequent requests for mental health services in writing. Therefore, the numbers of requests per other staff members, at the direction of the youth would be informative. For all the examples above, actual referral documents were not included in the records, so it was impossible to determine the elapsed time between the request for services and response to the request. Quality assurance monitoring regarding the time elapsed would be useful to ensure that emergent and routine requests were addressed in a time period consistent with that outlined in policy and procedure. Additional concerns regarding the youth's ability to independently access mental health services are included in the discussion regarding paragraph 9.
Recommendations	. Continue quality assurance monitoring regarding the elapsed time between requests for and provision of services. . Monitor response to requests for mental health assessment made by staff members.
Evidentiary Basis	. Review of provided documents (policy and procedure, youth records, psychology staff schedules) . Review of Ohio state statute . Staff interview

3.	**<u>Identification of Previously Unidentified Youth with Mental Disorders</u>: 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.**
Discussion	Per the facility verbal self assessment, the Behavioral Health Review Panel designated in policy and procedure entitled "Behavioral Health Assessment, Screening, Appraisal and Evaluation" had begun to review assessments performed on Tuesdays, with plans to expand to a review of all intake assessments by 4.1.11. Facility staff did report an example of a youth, who was admitted to general population, experienced a mental health decompensation and was referred to the mental health unit. Review of the available records for youth 330 revealed that on intake 5.21.10, diagnoses were assigned including: Bipolar Mood disorder, not otherwise specified; Conduct Disorder; Consider sexual abuse of a child-victim; Rule Out mood disorder secondary to a general medical condition; consider Posttraumatic Stress Disorder. This youth reported a history of self-injurious behavior via cutting and burning herself. There "is also a report in the file that the youth made a suicide attempt in January 2010, although the youth denies it." The mental status examination upon intake documented, "mood appears depressed…affect appears flat…being prescribed Risperdal." The youth was initially placed on observation status "to monitor adjustment" for one week, with no reported difficulties. The youth was recommended for placement in general population, however, she was maintained on the mental health caseload. The youth began to experience increased mental health symptoms 9.24.10 and a risk assessment was performed. As a result, the youth was placed on observation status. The next documentation available for review was a risk assessment update dated 9.29.10. It was challenging to follow the trajectory of this youth's mental health treatment, as there were multiple (approximately ten) late entry notes in the record all of which had an entry date of 11.1.10. This late documentation would make it impossible for staff to follow a youth's mental health treatment over time. 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 no case formulation to tie all the information obtained together in a c oherent package for the reader. This is an area that would be amenable to quality assurance, peer review process and clinical supervision.
Recommendations	. Complete implementation of draft policy entitled "Behavioral Health Assessment, Screening, Appraisal and Evaluation." . Quality assurance monitoring regarding re-evaluation of youth who experience an exacerbation of mental health symptoms or behavioral challenges. . Ensure that youth mental health documentation is done regularly, as late documentation does not have the richness of that performed immediately following a mental health contact. . Ensure the creation of a case conceptualization for each youth.
Evidentiary Basis	. Review of provided documents (e.g. Policy and Procedure, draft Policy and Procedure, youth records). . Staff interview

4.	**<u>Mental Health Assessment</u>: 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.**
Discussion	The policy provided "Behavioral Health Assessment, Screening, Appraisal and Evaluation" was partially implemented 1.1.11. Additional portions of this policy pending implementation included the review of all admission documentation for a specific youth via the Behavioral Health Review Panel slated for 3.1.11. A review of youth records available for off site review revealed reception assessment summaries and mental health appraisals performed at the time of admission. While these documents provided useful information for the determination of placement and initial treatment planning, they were variable in quality. Per the facility verbal self-assessment, "there will likely not be a big change in the charts other than increased fidelity to the SOAP note format…and more in depth assessments…you might see youth with diagnostic criteria review and case conceptualization." Administrative staff revealed that with the implementation of new policy and procedure, some quality assurance measures, specifically peer review, have begun. Documentation of peer review results was not included in the records available for off site review. A review of the ten most recent admission assessments performed at the facility was limited by the low percentage of these youth having current mental health diagnoses or treatment (all were referred to general population following assessment). With regard to those where a mental health diagnosis was assigned, the inclusion of a statement of specific diagnostic criteria indicating what specific symptoms the youth was experiencing now or in the past that justified the diagnosis was not always included. For example, documentation regarding youth 220 noted in the Reception Assessment Summary included a review of a group of symptoms the youth was experiencing, however, the document did not review the signs or symptoms the youth was experiencing that led the examiner to make a specific diagnosis. The only nod to the current diagnosis was "he

	reports a history of ADHD…indicated that he has a problem with alcohol and drugs." Based on this documentation, the youth was diagnosed with ADHD; Alcohol Abuse; Conduct Disorder; Cannabis Abuse; Rule Out Polysubstance Dependence; Depressive Disorder, not otherwise specified. Further review of the Reception Screening document, Ohio Youth Assessment Summary, and Psychology Intake Interview did not reveal a diagnostic formulation or case conceptualization. Despite the generation of multiple assessment forms, there was no document to tie all the information obtained together in a coherent package for the reader. This is an area that would be amenable to quality assurance, peer review process and clinical supervision.
Recommendations	. 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.
Evidentiary Basis	. Review of policy and procedure . Review of youth records . Review of other provided documents . Staff interview

5.	**<u>Adequate Mental Health Care and Treatment</u>: 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.**
Discussion	Per the previous monitoring tour, the facility implemented the Strengths Based Behavior Management System as of May 2010. The facility was in the process of revamping the mental health treatment program with the intent of implementing the New Freedom Phoenix program as the overarching treatment program for all facility youth. Per the facility verbal self-assessment performed during this monitoring tour, this program was fully functional on one housing unit. Staff from other units have been trained, and it was the facility goal to have implemented this program in all units by April 1, 2011. Additional information regarding the progress of the implementation of this program will be requested in the next monitoring tour. Although the implementation of the New Freedom Phoenix program was not observed during this monitoring tour, a review of the curriculum revealed that the participation and integration of direct care staff is imperative to its success. As stated in other areas of this report, there were concerns regarding the overall integration of direct care staff into the treatment plan for the youth. With regard to specific mental health treatment, the facility staff have completed the training regarding Trauma and Grief Component Therapy for Adolescents. The first of these groups were held on both the boys and girls mental health units during this monitoring tour 2.23.10. Portions of both group interactions were observed. In both cases the group leader was effective and youth were engaged in the group process. It was apparent that group leaders had made the effort to review the group material in advance, and to develop strategies that appealed to the youth in an effort to engage them in the discussion of a difficult topic. It was apparent that mental health staff were making efforts at co-facilitation of certain groups, a topic that was discussed in the previous monitoring report. Per the facility verbal self-assessment, psychology staff was taking the lead with regarding to trauma-based group therapies, while social work staff was taking the lead role with cognitive behavioral therapy (CBT) based group interactions. The staff were then acting as the co-facilitator for each other's primary group responsibility. While youth specialists were trained to facilitate CBT based groups, their investment and

	involvement in the group process was questionable. This issue will be discussed further in provision 7. A review of the group progress notes in the records available for off site review revealed some improvement in the documentation of group interaction. A review of the records of female youth revealed group notes that were appropriately written in SOAP format. The difficulty with the notes reviewed was that they were boilerplate, in that for youth attending the group, assessment and planning documentation was identical for several consecutive sessions. Review of the mental health documentation for male youth revealed that the most recent mental health group notes available for off site review were authored in August 2010. Therefore, these were not utilized to formulate an opinion of group therapy documentation. Per the facility verbal self-assessment, there were performance issues noted with social work and psychology staff with regard to documentation. The administrative staff estimated that three social workers were "not functional" and one psychology staff "lags behind." Administrators discussed plans to utilize available remedies with staff including the disciplinary process and performance evaluations in order to address documentation deficiencies. Review of the youth records available for off site review revealed documentation of individual contact with youth via psychology services. Much of this documentation was in regard to crisis management or the difficulties that the youth was experiencing on that particular day. Review of the documentation did not allow the reader to discern the youth's progress toward goals purported in the treatment plan, nor did they reference specific targeted interventions proposed in the youth's treatment plan. Per the facility verbal self-assessment, in the recent months, staff have been diligently working to complete treatment plans for youth in the new integrated format. The administrative staff were aware of the need for youth progress notes to reflect goals specified in the treatment plan and the youths progress (or the lack thereof) toward a specific goal. This type of documentation was not noted in the records available for off site review. It is hoped that with the planned change to an Integrated Treatment Plan that this information will logically flow into the progress notes. Ongoing clinical supervision and quality assurance may be helpful for staff when adjusting to these new documentation requirements. Given the above, it is apparent that while some treatment is occurring, improvements to the overall treatment program (already planned by the facility) and documentation of treatment provided will be necessary for the

	facility to meet the requirements of this provision. In the upcoming monitoring tour, additional information regarding the facilities mental health treatment program will be requested and reviewed.
Recommendations	. Implement planned mental health programming . Improve documentation of group therapeutic interaction . Improve documentation of individual therapeutic interaction . Ensure the provision of evidence based group therapeutic interactions . Expansion of the group curriculum available for male youth. . Continue the integration of treatment provider disciplines in order to achieve an interdisciplinary model. . Engage and encourage direct care staff to participate in group modalities and in the overall treatment program for the youth.
Evidentiary Basis	. Review of provided documents (e.g. group schedule, youth records, policy and procedure, description of treatment modalities) . Observation of three group interactions . Youth interview . Staff interview

6.	**<u>Treatment Planning</u>: 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.**
Discussion	Per staff interview and document review, the facility has implemented policy regarding the Interdisciplinary Treatment Team as well as a revised format/process for the documentation of treatment planning, via the creation of the Integrated Treatment Plan. It was reported that the facility adopted these policies 1.1.11, w ith the goal of completing the revised format for all youth as of 3.1.11. F or additional information regarding Treatment Planning, please see the discussion regarding the two following paragraphs (7 and 8). Staff interviewed for the verbal facility self-assessment indicated the "need for lots of training for staff…especially social work staff…they will need help with the development of the treatment plans with the goal of looking forward to discharge."
Recommendations	1. Completion of the Integrated Treatment Plan for all youth. 2. Begin Quality Assurance monitoring of the process and documentation included in the Integrated Treatment Plan. This may include peer review and clinical supervision for those staff members who are new to this type of treatment documentation.
Evidentiary Basis	. Staff interview . Review of provided documents (e.g. Policy and Procedure, Integrated Treatment Plans)

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 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; andh. Document treatment team meetings and planning in the youth's mental health records.**

Discussion	Per a document review performed for the previous monitoring report, the policy and procedure implemented 1.1.11 entitled "Interdisciplinary Team" designated the staff who should be included in the Interdisciplinary Team, "a unit manager, Clinician(s), Provider(s), and staff from Mental Health Services, Psychiatry, Education, Psychology and Recreation. Other participating staff may be included, such as from medical services, religious services or administration." Per policy, the team will meet regarding each youth "at least monthly" and meetings should include the youth and their parent or guardian. At the time of the monitoring tour, there were functioning Interdisciplinary Teams (IDT) on the designated mental health units for both male and female youth. An IDT meeting was observed during the tour regarding youth 999 and youth 110. The psychiatrist was in attendance for these two meetings, additional team members present included the youth, psychology, occupational therapy, unit director, mental health nurse and the unit psychologist. The youth specialist (direct care staff) attended peripherally. The specialist was stating on the dais above the table where the staffing meeting was held. The specialist appeared to be listening to the conversation; however, telephone calls and other direct care staff coming up to the desk frequently interrupted this. As discussed during the monitoring tour, it will be necessary for the IDT to include the youth specialist as a full-fledged, functioning member of the team. Interviews performed with the psychiatrist during this tour revealed that due to limited clinical resources, the psychiatric attendance at IDT was limited. A review of the documentation of attendance at IDT meetings during the period of 11.11.10 and 1.13.11 revealed no signatures of the psychiatric physician. Interviews with youth revealed variability with regard to this issue. Some youth indicated that the psychiatrist "he comes to my team sometimes." Other youth reported that the psychiatrist had not attended their IDT meetings. Youth acknowledged participating in their scheduled team meetings, but some youth opined that IDT should be more frequent. One youth reported that in their opinion, the development of treatment goals was rushed, rapid and left until the end of group, "the goals are last minute…and tacked on to the end of the meeting…this place is inconsistent." This final comment was observed by the consultant, and will be discussed in the ensuing paragraphs. For the two IDT meetings observed during this tour, staff appeared interested and knowledgeable regarding the youth. The youth's specific behavioral challenges as well as the hypothesis for these challenges were discussed. In light of the extensive discussions observed, a decision

	regarding management strategies or documentation of treatment planning interventions would be expected. Unfortunately, the translation of the rich discussion observed in treatment team into an intervention and practice regarding a specific youth was not observed. This was most evident in the IDT regarding youth 110. Youth 110 had reportedly been confined to his room for four days at the time the IDT was observed. A review of the treatment modalities employed for this youth revealed that seclusion was the predominant treatment modality in effect since November 2010. There were some individualized behavioral plans included in the documents, however, the plans provided nothing with regard to reward for positive behaviors with the target desired behavior per the plan dated 1.15.11 being that the youth would come out of his room. More recently, the youth was reportedly experiencing increasing psychiatric symptoms including irritability, agitation, mood swings and psychotic thought processes. At the time of admission to the facility, this youth had experienced mental health symptoms inclusive of aggression and agitation. He had responded to treatment with depot neuroleptic medication, in that his symptoms resolved and for the period 7.25.10 through 11.11.10 there were no reported incidents of agitation of aggression, "he was clear, logical, and on task." Per staff report and medical record review, this youth began to experience extrapyramidal side effects of the depot medication. Rather than a trial of anticholinergic medication or other medications commonly utilized to ameliorate side effects associated with neuroleptic medications, the medication was discontinued, resulting in the current psychiatric decompensation. It was likely that the lack of psychiatric resources contributed to this pharmacological mishap, as had more resources and attention been available to this youth, alternate modalities may have been trialed. Increased interventions per psychiatry could have included more frequent medication management appointments and psychiatric attendance at this youth's treatment team meetings. The youth was reportedly now refusing oral medications, and per report of the IDT, all the youth's symptoms and treatment refusals were intensified by his inability to tolerate the stimulating environment of the unit, hence, he remained in his room for extended periods of time. Staff were aware that keeping this youth confined to his room was not appropriate, "it only seems to make him more psychotic." Staff noted that the youth had begun to refuse to leave his room, refuse to bathe, refuse to comply with

	psychotropic medication, and demonstrate increased psychotic symptoms, however, as noted in the discussion above, they were experiencing difficulties with the development of a treatment plan and intervention to address the youth's difficulties. Ultimately, with some encouragement, staff were able to devise a workable treatment intervention pending response to a request for involuntary psychotropic medications and consideration for an alternate placement setting. While this was a good start, the IDT challenges with respect to the development of a written plan and training for youth specialists (direct care staff) were obvious, as the consultant observed the youth in his new programming environment 24 hours after he was relocated with a revised individual behavioral management plan. Unfortunately, direct care staff had no written instructions available to them at that time, and had reportedly not received any training regarding the management of this particularly challenging youth. Per verbal report of facility mental health staff, the goal of the plan was to reduce the level of stimulation the youth was exposed to, while ensuring him two on one interaction with staff. While the reduction in stimulation was achieved, without a plan in place 24 hours following the move, the youth was more isolated, as direct care staff were not aware of the planned interaction. Documentation regarding IDT meetings was provided per the document request. The documentation included meeting sign in sheets and meeting minutes. A review of the sign in sheets did not reveal any signatures of psychiatry indicating no documentation of psychiatry attendance. The meeting minutes included general information regarding the unit and scheduling of activities as well as a listing of youth who were scheduled for a "progress review." The quality of documentation was variable between the units. Some units documented discussion regarding the youth goals, while others had briefer documentation. The better documentation was noted in for those teams functioning on designated mental health treatment units. There was documentation located that indicated the IDT awareness of a need for improvement in collaboration and team functioning. Examples gleaned from a review of the IDT minutes are as follows: 11.9.10 – "staff need to watch talking in front of youth." 11.23.10 - "still concerns that psychiatry not consulting with treatment team about youth meds." 12.14.10 – "units have 'heavily used the consequence of no free time'…early to bed is also being used too often"

	1.25.11 – "get the train back on track with the absence of the unit manager and irregular staff." Issues with team functioning were observed during the monitoring tour and discussed with facility staff. The challenges were multifactorial. Examples outlined in the discussion above, specifically the lack of integration of direct care staff in the IDT was apparent not only in the observation of IDT, but also in observation of direct care staff on the individual units. For instance, during an observation of a group therapy on the girls mental health unit, there were frequent interruptions consisting of staff knocking on doors to enter the unit and youth being summoned to step out of group for brief periods to sign documents. The most egregious event occurred when a girl was discussing a traumatic event that had occurred in her life (i.e. being gang raped) and four male direct care staff seated in the back of the room were talking amongst themselves and laughing. This was disruptive, counter-therapeutic, insensitive and dismissive of the youth's experiences. This issue was reported to administrative staff, and the location of the group interaction for the female youth was changed. When the behavior of direct care staff during group was mentioned to mental health staff, they indicated it was a frequent occurrence, however, efforts to change staff behavior had been met with resistance. Mental health staff also mentioned concerns that if direct care staff were confronted or reported, that the physical safety of the mental health staff could be compromised. While mental health staff did not indicate that this had been an issue, the fact that it was stated at all was concerning. Throughout the tour the lack of collaboration between mental health staff and direct care staff was apparent. It is recognized that this concern on the part of mental heath staff may be a symptom of a larger issue. It was interesting that the facility chose to relocate the group rather than deal with the staff. Interviews with youth conducted the next day revealed that youth were aware of the consultant's discussion with administrative staff, and that direct care staff had vented frustration in front of the youth. Again, this inappropriate discussion in the presence of the youth is a sign of the direct care staff's lack of personal involvement in the IDT.
Recommendations	. Ensure psychiatric resources are available to allow participation in Interdisciplinary Treatment Team meetings. . Educate all staff regarding the sanctity of group therapeutic process

	. Ensure that direct care staff are included in and valued members of the IDT . Begin Quality Assurance monitoring of treatment planning efforts and IDT meetings. . Increase staff training/education regarding the timely formulation of a treatment plan and interventions developed as a result of, among other things, the rich discussion in IDT. These plans must then be implemented, first via training direct care staff.
Evidentiary Basis	. Staff Interview . Observation of Interdisciplinary Treatment Team meetings . Review of provided documents (e.g. IDT meeting minutes, review of youth records). . Observation of group therapies . Youth interview

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.**
Discussion	Interviews conducted during the monitoring tour revealed that the facility was in the process of collating the multiple treatment and case planning documents into one overarching document entitled Integrated Treatment Plan. Per the recently implemented policy entitled "Behavioral Health Services" the Integrated Treatment Plan is "a formal strategy developed to address the habilitation, education, rehabilitation, social, mental health and psychiatric needs of a specific youth. The plan is developed by an assigned Clinician or Provider in collaboration with the youth and the Interdisciplinary Team (IDT), and is implemented by both the youth and all Behavioral Health Services staff who work with the youth." Per interviews, the facility implemented the policy beginning 1.1.11. Facility staff gave different estimates as to the number of youth whose treatment plans had been rewritten to reflect the requirements of the above noted policy and procedure. Documentation regarding the names of those youth for whom this task had been completed was requested (this was a request made during the monitoring tour) however, was not included in the documents available for off site review. Staff interview revealed it was their goal to complete this process by March 1, 2011. A review of 10 Integrated Treatment Plans provided for review revealed variable quality of the documentation. For example: Youth 888 – The goals purported via this youth's plan included, "to reduce mental health symptoms and their impact on my daily life…I will address my sexual offense and learn to maintain health boundaries…I will recognize how my feelings of being abandoned influence my current relationship; I will work towards improving my social skills." While these were admirable goals supported by documentation of the presenting issues,

	they were not measurable. There were objectives included with each goal, and some of these were measurable, some were not. Similar issues were noted with the other Integrated Treatment Plans available for review. 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. Mental health administrative staff interviewed during the facility verbal self-assessment revealed that progress notes specifically related to the youths Integrated Treatment Plans were in the beginning stages of implementation, "we may not have those…we are just getting started with that." 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).
Recommendations	. Complete Integrated Treatment Plans for all youth. . Begin quality assurance monitoring of treatment plan documentation, and implementation.
Evidentiary Basis	. Staff interview . Review of provided documents (e.g. draft policy and procedure) . Review of youth records

9.	**<u>Access to a Qualified Mental Health Professional</u>: 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.**
Discussion	Per the review of policy and procedure entitled "Mental Health Referral, Evaluation and Disposition," and the associated policy entitled "Referrals to Mental Health Services" performed for the previous monitoring report, these documents outline the process for any facility staff to refer a youth for an assessment to determine the need for mental health services. There are designated time limits for response to requests. Psychology must respond within five working days, psychiatry within ten working days and if the request is for additional evaluation, there is a fourteen working day response window. Per a review of mental health staff schedules, it appeared that mental health staff scheduling included both evening (until 8:00 p.m.) and weekend hours. Per documentation provided via the document request, information regarding youth's request for mental health services and the time lapse until a provider saw them was reviewed. There were four instances documented, in all four cases, the youth were reportedly seen the same day, within four hours of the request. Per additional documentation provided, "youth…and staff may request that psychology staff meet with a youth…psychology staff offices re located on the units, staff are accessed easily and formal requests are rare." Interviews with youth revealed variability in their perception of both their ability to request mental health services and the response to their request. Only one youth interviewed indicated that following completion of a form "that you put in the box over there" would result in a response from mental health. Another youth stated, "when it is after hours, you have to ask staff to call for you…there are forms…the staff has never told me no." Some youth indicated that they had to access mental health services via direct care staff, "and sometimes they don't like you and don't want to do it." Another youth reported, "we don't have to fill out the request because [psychology staff] is there…but if they aren't, staff has to call…and sometimes they don't want to do it…your regular staff usually will, but others could care less." This particular youth indicated that he/she did not know how to access mental health care in any other way. Finally, several youth indicated that while they were able to access mental health staff,

	"they really aren't able to spend enough time with me…there is so much going on." As discussed with facility staff during this monitoring tour, the policies noted above do not indicate the method by which youth can independently access mental health services. Per these policies, access is limited to youth who are referred by other staff members. In the past, a review of the youth handbook revealed instructions for youth to access mental health services via direct care staff. A revised version of the youth handbook dated 10.29.10 was provided for review during this monitoring tour, per the revised handbook, youth who want to access mental health care can "complete a 'Request for Services' form, which is located on the unit." The handbook does not instruct the youth what to do with the written request following completion. Staff interviews revealed that youth are "verbally instructed to put the request in the medical sick call box…and this is in their welcome letter." This must be delineated, such that youth are instructed how to access mental health care and do not have to go through staff in order to access care. There are situations where staff could unfortunately impede a youth's access.
Recommendations	. Determination of method by which a youth can independently request mental health services which is clearly spelled out in the youth handbook and policy and procedure . Quality assurance monitoring regarding the time elapsed between a request for services and clinical contact with the youth . Ensure the youth's open access to mental health services
Evidentiary Basis	. Facility verbal self-assessment . Review of provided documents . Youth interviews

10.	**<u>Mental Health Involvement in Housing and Placement Decisions</u>: 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.**
Discussion	Per the policy and procedure entitled "Mental Health Referral, Evaluation, and Disposition" reviewed for the prior monitoring report, 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. Youth demonstrating serious mental health issues and/or who are determined to be unable to adequately manage the demands of living in the general population are referred for placement on an alternative living unit." Policy and procedure implemented January 1, 2011 entitled "Behavioral Health-Special Services Living Units" includes "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 guided the creation of the "Behavioral Health Review Panel" whose responsibility it is to "review information obtained in the reception process and determine the best options for each youth in regard to housing, programming…" As of January 1, 2011, the Behavioral Health Review Panel had begun to review reception assessment summary documents for youth who arrive on Tuesday of each week. During the verbal facility self-assessment, staff indicated plans to expand the Behavioral Health Review Panel to include all youth admitted by March 1, 2011. Staff further indicated that they have had no occasion where the recommendations regarding a housing unit made via either the reception assessment summary or the Behavioral Health Review Panel were not accommodated. At the time of this monitoring tour, there were two mental health units on campus; one designated for female youth (Davey capacity 12 youth), the other for male youth (Buckeye capacity 18 youth). Review of youth intake screenings and completed intake assessments for the ten most recently admitted youth revealed that 100% of these youth were recommended for placement in general population, with, in some

	cases, additional treatment modalities (e.g. substance abuse) recommended. It would be interesting to note if all of these youth were able to maintain in the general population. The facility could consider tracking youth who are initially recommended for general population, but ultimately require an increased level of care. This could prompt changes in the intake assessment process.
Recommendations	. Fully implement the Behavioral Health Review Panel . In the next monitoring period, provide minutes from the Behavioral Review Panel . Consider quality assurance regarding youth who are initially recommended for general population but ultimately require an enhanced level of care. Consider quality assurance measures to review the accuracy and completeness of the assessment
Evidentiary Basis	. Staff interview . Review of provided documents (e.g. Policy and Procedure, and ten sample youth intake assessments) . Review of youth records

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.**
Discussion	Per staff interview during the monitoring tour, the facility verbal self-assessment, and a review of the provided documents, there were staff shortages at the Scioto facility, which were compromising youth mental health care. For example, until September 30, 2010, the facility had psychiatric physician coverage at one full time equivalent (FTE). At the time of the current tour, the facility was stretched with regard to psychiatric resources, as they currently had a total of 0.42 FTE (a reduction from 0.7 FTE during the prior monitoring tour). Please see the discussion regarding provision 13 for further information regarding the facilities recruitment attempts in the area of psychiatric services. With regard to psychology, the facility verbal self-assessment reported a total of four psychologists and six psychology assistants on staff. Per interviews conducted during the facility tour, there were a total of seven psychologists (three licensed) plus a psychology supervisor. There were two psychology assistants. Of the seven psychologists, five were assigned to the assessment units, the remainder to the program units. Per interviews conducted during the tour, there were currently a total of 14 social workers budgeted at the facility. At the time of the tour, three staff were out for various reasons, leaving 11 social work staff actually on site providing services. Additional mental health staff included mental health nurses and occupational therapists. At the time of the tour, there were two full time mental health nurses providing services at the facility as well as two full time occupational therapists. Per observation and interview, the current mental health divisions were making renewed efforts to work together to integrate treatment for the facility youth. At the time of this monitoring tour, the facility was in the

	process of consolidating treatment planning documentation into one overarching document, the Integrated Treatment Plan. Staff interviewed revealed various estimates regarding the number of youth where this process had been completed. Per the facility verbal self-assessment, training regarding the New Freedom Phoenix program, (a cognitive behavioral/aggression replacement therapy/problem solving based program) had been completed and this modality had been implemented across campus. Additionally, trauma training had been provided to the girls units and the boys mental health units. The first trauma based treatment groups on both the boys and girls mental health units were held during this monitoring tour.
Recommendations	. Recruit and fill current vacancies . Determine the need for additional staff via workload indicators . Improve coordination between staff disciplines . Complete and implement the Integrated Treatment Plan . Begin quality assurance and clinical supervision regarding the Integrated Treatment Plans.
Evidentiary Basis	. Staff interview . Review of provided documents

12.	**<u>Medication Notice</u>: 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.**
Discussion	Per the policy and procedure reviewed for the previous monitoring report entitled "Psychotropic Medication, Use and Management" education including "addressing the goals, risks, benefits, and potential side effects associated with any given medication is given to each youth and his or her parent or guardian… the prescribing physician provides an explanation of the potential consequences of not taking the medication and explains that the youth has an opportunity a consent or withhold consent to be treated…provides guidelines within which medical professionals may petition the court to authorize involuntary administration of psychotropic medication." Staff interview performed during this monitoring tour revealed that the current psychiatric practitioner was not performing informed consent for youth who enter the facility prescribed psychotropic medication where medications are continued. It was discussed with the provider during the tour that generally accepted practices as well as facility policy and procedure require documentation of informed consent for treatment with psychotropic medication, whether this was a new prescription or a continuation of care from another provider. T he psychiatric provider reported that he does attempt to contact the youth's parent or guardian regarding new medication prescriptions. Given that the psychiatrist was not performing appropriate informed consent regarding treatment with psychotropic medications when youth enter the facility prescribed a medication, documentation of informed consent was not located in the initial psychiatric evaluations of these youth. Further review of youth records regarding new medication starts instituted by the psychiatric provider did not reveal documentation of the appropriate

	elements of informed consent. Generally accepted practices require documentation of a discussion with the patient of the risks, benefits, side effects, and alternatives to treatment with a particular medication. This was not noted in the facility progress notes. Interviews with facility staff to complete the verbal self assessment revealed that staff were aware of the challenges and deficiencies in the area of informed consent for psychotropic medication, "we hope to see more consistency…but we are concerned due to the recent sporadic and scarce [psychiatry] coverage." Staff further reported that documentation requirements were reviewed with the psychiatric physician, "the doctor is trying to increase contact with the parents of the youth…and we are in the process of developing information for the youth and their parents on side effects of the psychiatric medications." Interviews with youth performed during the monitoring tour revealed that youth were able to name some of the medications prescribed. They were also able to name some side effects of the medication. There was no information located in the documents regarding petitions for authorizations to involuntary administer medications.
Recommendations	. Improve documentation regarding informed consent that is consistent with generally accepted practices and facility policy and procedure. . Consider a peer review process for informed consent and other psychiatric documentation . Consider the development of or use of commercially available information regarding side effects of psychotropic medication that is written such that an individual unfamiliar with medical jargon would understand the information.
Evidentiary Basis	. Youth record review . Review of provided documents . Youth interview . Staff interview

13.	**<u>Mental Health Medications</u>: 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.**
Discussion	Per the facility self-assessment and document review per formed during the prior monitoring period, the facility has policy and procedure in place entitled, "Psychotropic Medication, Use and Management." This policy "provides the parameters for using medication for psychiatric purposes…education addressing the goals, risks, benefits, and potential side effects associated with any given medication." The Ohio Department of Youth Services also had a document entitled, "Recommended Laboratory Monitoring Frequency Guidelines." This document was updated and approved by the current psychiatric provider as of 2.22.11. Per the presentation provided at the outset of the tour as well as staff interviews, psychiatric resources at the facility were reduced over the prior monitoring tour. At the time of the current tour, there was one psychiatric provider, accounting for a total of 17 hours of clinical services per week. Reportedly, this physician had interviewed for a potential full time position at the facility, and an offer of full time employment was extended to him on or about 2.24.11. A review of the physician's curriculum vitae revealed that he completed a fellowship in child and adolescent psychiatry, and was board certified in adult psychiatry by the American Board of Psychiatry and Neurology. There was no documentation of board certification in child and adolescent psychiatry. As one full time equivalent was a reduction in psychiatric resources over those available at the facility in August 2010, administrative staff had performed an analysis of resource requirements. This document, entitled "Rationale for the Distribution of Psychiatry Hours" dated 2.22.11 made

	assumptions that approximately 50% of the youth committed to DYS will receive mental health services. It is opined that this is an underestimate of the number of youth who will require services. Per a review of the literature, "in a review of decades of research on psychiatric disorders in children…prevalence rates for current psychiatric disorders were estimated to be 16.5 percent in adolescents…as many as 65 percent of youth in the juvenile justice system have a diagnosable psychiatric or substance abuse disorder." (Desai R, Goulet J, et al. Mental Health Care in Juvenile Detention Facilities: A review. J Am Acad Psychiatry Law 2006; 34: 204-214.) The rationale further divided youth into minimum, moderate, and high levels regarding the level of mental health care they would require. It was opined in the rationale document that 60% of youth would require a minimum level of care, 27% of youth would require a moderate level of care, and 13% of youth would require a high level of care. Based on this, a calculation was derived inclusive of both direct and indirect clinical service requirements. This resulted in an estimation of yearly total hours at this facility at 2496 hours. Per the rationale document, one full time equivalent would be sufficient to cover this requirement. Interestingly, another facility, where a total of 1872 hours were estimated was also assigned one full time equivalent. It is recommended that as psychiatric services that are in keeping with generally accepted practice standards are implemented at the facility, that the facility re-evaluate the need for additional resources. Further challenges with psychiatric services were reported, as the administrative psychiatry position via state office was also vacated in the intervening period between the two monitoring tours. Currently, even if the part time psychiatric provider accepted full time employment, there were no resources for coverage (e.g. vacation, sick time) or for peer review processes. Staff interviewed revealed active recruitment attempts to fill the administrative psychiatry position, which could allow for coverage. In the interim, in an effort to provide peer review and coverage, administrative staff were exploring the potential for a contract with a local hospital. Given the limited psychiatric clinical resources, the psychiatry clinic at the Scioto facility was not fully functional at the time of the tour. The psychiatrist was making efforts to perform initial psychiatric evaluations and ongoing medication management. The psychiatrist was also attending some interdisciplinary team meetings (one of these was observed during this monitoring tour). Interviews with youth revealed variable reports regarding their satisfaction with psychiatric care. Some youth were frustrated and indicated that they had to wait long periods to see the physician. This was observed during psychiatry clinic, where a youth was

	identified at admission as requiring a psychiatric evaluation, but due to limited resources, there was a six week interval between admission and evaluation. Other youth reported that while they saw the physician at a reasonable interval, "he is just so busy…that he doesn't listen…and sometimes I think he blows me off." Other youth had more positive reports, "the doctor comes to my treatment team." The psychiatrist reported good ability to obtain laboratory examinations following a physician order, and that abnormal lab results were communicated via a telephone call to the physician. The psychiatrist reported taking after hours call for psychiatric emergencies at the facility, and per interviews with administrative staff, there were plans to add a requirement for after hours availability into the full time job description. There was, however, 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; generally accepted practice is that the psychiatrist would be informed and aware that a youth on his or her caseload required enhanced supervision. Psychiatry clinic was observed during the monitoring tour. The psychiatrist did a good job establishing rapport with the youth. He queried the youth regarding signs and symptoms of mental illness inclusive of historical data. The physician reviewed the youth's medical record inclusive of school and behavioral information. Review of psychiatric documentation regarding the last ten youth admitted to the facility who were prescribed psychotropic medication revealed consistent deficiencies in documentation. For example: Youth 444- This youth was admitted to the facility four days prior to the initial psychiatric evaluation dated 1.27.11. The youth was prescribed Abilify, an atypical antipsychotic medication, at the time of admission. This medication was continued following the initial evaluation, however, the evaluation makes no note of a review of weight or vital signs, monitoring for abnormal involuntary movements, nor did it indicate laboratory examinations were ordered or reviewed. This youth was diagnosed with Posttraumatic Stress Disorder, as well as two rule out diagnoses (mood disorder, not otherwise specified and conduct disorder). As there was no diagnostic formulation included in the dictation, it was unclear as to the specific symptoms that the youth was experiencing that led the physician to this particular diagnosis. Additionally, while per

	the document, the youth indicated the medication was prescribed to "keep…calm and...stabilize…mood," there was no documentation by the physician regarding the indication or target symptoms associated with the prescription of this medication. Youth 555 – This youth was admitted to the facility approximately one week prior to the initial psychiatric evaluation dated 1.27.11. This youth was prescribed Abilify, an atypical antipsychotic medication at the time of admission. T his medication was continued, however, the physician documented "I am not certain of the effectiveness." The evaluation makes no note of a review of weight or vital signs, monitoring for abnormal involuntary movements, nor did it indicate laboratory examinations were ordered or reviewed. The youth was diagnosed with "Likely" Posttraumatic Stress Disorder, as well as a rule out diagnosis of conduct disorder. As there was no diagnostic formulation included in the dictation, it was unclear as to the specific symptoms that the youth was experiencing that led the physician to this particular diagnosis. A dditionally, while per the document, the interview with the youth revealed the medication was prescribed to "help with mood swings and mood changes and irritability," there was no documentation by the physician regarding the indication or target symptoms associated with the prescription of this medication. Youth 777 – This youth was admitted to the facility one day prior to the initial psychiatric evaluation dated 1.21.11. T his youth was prescribed the antidepressant medication Prozac, the anti-epileptic/mood stabilizing medication Lamictal and the atypical antipsychotic medication Risperdal upon admission. T he evaluation makes no note of a review of weight or vital signs, monitoring for abnormal involuntary movements, nor did it indicate laboratory examinations were ordered or reviewed. The youth was diagnosed with: Cannabis abuse; mood disorder, not otherwise specified, and a rule out diagnosis of conduct disorder. As there was no diagnostic formulation included in the dictation, it was unclear as to the specific symptoms that the youth was experiencing that led the physician to these particular diagnoses. Additionally, while per the document, the interview with the youth revealed that he was unclear as to the reason why medications were prescribed, medications were continued with out specific documentation by the physician regarding the indication or target symptoms associated with the prescription of these medications. On a positive note, the evaluations reviewed were detailed with regard to

	the documentation of the youth's historical information. It is possible that the documentation deficiencies are the result of diminished clinical resources, as interviews with youth revealed that as in the prior monitoring tour, youth interviewed had knowledge regarding their prescribed medication, they were able to discuss the symptoms that the medication was addressing, they indicated that laboratory examinations had been performed during their stay at the facility and they were able to discuss basic medication side effects. At the time of the monitoring tour, there were 138 youth housed on campus. Of these, 33 were prescribed psychotropic medication. This indicates that 24% of the youth housed at the facility were prescribed psychotropic medication. Of the 33 youth prescribed psychotropic medication, nine were prescribed stimulant medications as a result of diagnoses including Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder or other Axis 1 mental health disorders.
Recommendations	. Recruit psychiatric physicians to fill available positions . Determine how vacation and sick time will be covered . Continually assess the number of FTE required to perform necessary psychiatric duties (i.e. clinic, attendance at treatment team meetings). . Improve psychiatric documentation (consider quality assurance monitoring or a peer review process).
Evidentiary Basis	. Staff interview . Clinic observation . Treatment Team observation . Youth record review . Review of provided documents (e.g. policy and procedure, lists of youth prescribed medication, examples of initial psychiatric evaluations, and mental health caseload documentation) . Youth interview

14.	**<u>Mental Health and Developmental Disability Training for Direct Care Staff</u>: 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.**
Discussion	Per the facility verbal self-assessment performed during this monitoring tour, in the intervening period since the last visit, the facility has provided a three day mental health intensive training (for mental health staff), an update on the behavioral health policy and procedure (for all staff), trauma training (for staff assigned to the girls units and the boys mental health unit, and training regarding self injurious behavior (for staff assigned to the girls units and the boys mental health unit). It was discussed that the three day mental health intensive training did not include direct care staff. Mental Health and administrative staff indicated that the purpose of this three day training was to assist staff with the treatment team process. Direct care staff are an important part of the youth's treatment team, and unfortunately, they were excluded from this experience. There were several instances witnessed during this monitoring tour that provided evidence and gave credence to the fact that direct care staff generally do not consider themselves to be an integral part of the treatment program. This is an area that will require a cultural shift at the facility, inclusive of teamwork, integration and training. Unfortunately, despite the document request requirements for a spreadsheet staff indicating all trainings attended and dates of completion, documentation of staff attendance at the trainings noted above was not included in the documents available for off site review. Per staff interview, they have "not had the time to address the requirements of provision 14 or 15 thoroughly." For additional discussion and information regarding recommendations, please see the discussion regarding provision 15 below. As stated in the previous report, the goal of this provision paragraph is to provide training to facility staff such that they have a working knowledge of the youth's challenges (both from a mental health and developmental perspective) and to provide them with strategies to assist in their daily supervisory tasks with the youth. Training for direct care staff is important as in the correctional setting; they function as the de facto parents of the youth in their care. As direct care staff are an integral part of the youth's treatment team, they should be aware that due to specific mental health

	diagnoses, youth may have special needs (i.e. a youth diagnosed with ADHD may not respond to you the first or even second time that you call his name because he is distracted by extraneous stimuli). They should also be aware of which youth are being treated with psychotropic medication and have a basic knowledge of the potential side effects of the medication so that they can monitor the youth in their care.
Recommendations	. Continue development of Mental Health Unit training . Create a s preadsheet that delineates staff attendance and completion of required training modules. . Develop a mandatory training schedule for staff who provide care to youth on the mental health case load. . Facility should make an appraisal of their staff training needs and develop curriculum to address these needs.
Evidentiary Basis	. Review of provided training module curriculum . Review of provided training documentation . Staff interview . Observation on the youth mental health units

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.**
Discussion	The document request for this monitoring period included "spreadsheet of staff indicating training programs completed and dates of completion for the time period from 2.22.10 to 2.11.11." In response to this request, a listing of 11, presumably mental health staff, employees was provided, with documentation of their attendance at trainings including "youth advocate training, MIS self-study, medical risks of restraint, MYR policy review, MYR practice Q1, CPR/first aid, release authority, youth grievance training, SBBMS, emergency response training, mental health, MYR practice Q2, verbal strategies, planned intervention, report writing, structured programming, MYR practice Q3, annual policy review, standard precautions and TB prevention, MYR practice Q4, mechanical restraints, ethics, behavioral health, and cultural competency." Per the facility verbal self-assessment, they have provided training regarding the cognitive behavioral and trauma based treatment programs, however, documentation of these trainings was not included in the records provided for review. Staff indicated that, "we have not had the time to address the items in provision 15 thoroughly...we have some ideas and have plans to develop a curriculum, and a schedule." Staff discussed plans to develop a quarterly training regarding specific mental health issues that could then be repeated on a quarterly basis. It was discussed during the tour that a thoughtful planned approach to staff training that addresses the requirements of this provision would be appropriate. In the future, the facility should include data regarding training in the required mental health subject matter areas delineated in this paragraph. This data must include not only training for mental health staff, but training for all facility staff who interact with youth (e.g., direct care staff, teachers, etc.). In the prior monitoring period, policy and procedure entitled "New

	Employee Orientation and Basic Academy Training" was reviewed. This document outlined specific pre-service training topics for new staff. These include: ba sic and fundamental 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. Specific training modules were provided for review in preparation for the prior monitoring report. T hese 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." Unfortunately, while the document request provided for this monitoring period included a requirement for the production of a spreadsheet of staff attendance and training completion, this was not included in the documents reviewed. Attendance documents that were provided for review for the previous report included participation and attendance until December 2009. Given changes in programming and staff turnover, more recent training documentation is required.
Recommendations	. Continue development of Mental Health Unit training . Create a s preadsheet that delineates staff attendance and completion of required training modules. This must be provided for all staff disciplines. . Develop a mandatory training schedule for staff that provide care for youth on the mental health case load.
Evidentiary Basis	1. Review of provided training documentation. 2. Review of the previous monitoring report. 3. Staff interviews.

16.	**<u>Suicide Prevention</u>: 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.**
Discussion	Per a meeting with key staff, where a verbal self-assessment was provided, mental health staff "review the precautionary status list weekly and monitor youth who are placed on suicide status." Staff noted anecdotally that the number of youth requiring precautionary status has decreased in recent weeks. The consultant discussed with key staff that per experts in the field of suicide prevention, a decrease in the number of youth identified is likely multifactorial. While it may be the result of improved treatment and intervention; or as facility staff hypothesized, the result of youth housed on mental health units settling into the facility milieu; it imperative that the facility ensure that the this reduction is not the result of a lack of identification of youth at risk for self-injury. Per a review of "Guiding Principles to Suicide Prevention in Correctional Facilities" by Lindsay M. Hayes published in the National Center on Institutions and Alternatives, 2007, " A lack of inmates on suicide precautions should not be interpreted as meaning that there are no currently suicidal inmates in the facility, nor a barometer of sound suicide prevention practices. We cannot make the argument that our correctional systems are increasingly housing more mentally ill and/or other high-risk individuals and then state there are not suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be 'zero' number of inmates on suicide precautions; rather the goal should be to identify, manage and stabilize suicidal inmates in our custody." A review of the names of all youth placed on suicide watch status between 11.11.10 and 2.11.10 revealed 36 instances of precautionary status. Of these 36 instances, four youth required precautions a total of two times, two youth required precautions a total of three times, and one youth required precautions a total of four times. As such 16 instances were accounted for by six youth. This indicates that there is a subset of youth who may require additional mental health intervention and suicide precautions. The provided policy and procedure entitled "Suicide Prevention and Response" was reviewed for the prior monitoring report. It appeared, however, per a review of the documents provided that this policy and procedure, number 404.03, was currently "pending" as noted in the listing

	of all mental health and behavioral health services related policies. The consultant was not clear regarding this policy status. Per the facility verbal self-assessment performed during this monitoring tour, the facility implemented revised policy entitled Behavioral Health Services as of January 2011, and it is questioned if this prompted a need to review and revise policy and procedure regarding suicide prevention. One example of an audit tool and one example of a compliance summary regarding suicide prevention and response was provided for review as part of the request regarding quality assurance monitoring. The utility of these documents was limited as there was no date included on either document, so it was impossible to determine when the audit or the compliance summary was conducted. Regardless, the audit tool form form indicated that the sample size should be "10% of youth population and/or no less than 10 samples." The document then indicated that "all CBT youth and females MH records" were audited. The form did not indicate the total number of records reviewed. There was notation of 100% compliance across five areas related to suicide prevention including a review of the nursing intake form, receipt of a risk assessment for those youth identified as being at risk, assurance that risk assessments performed by staff other than psychology resulted in the youth's placement on suicide watch, that all risk assessments are completed within four hours of the identification of suicide or self injury risk, and that youth shall be removed from precautionary status by psychology staff following a clinical assessment and document the revocation of precautionary status in the mental health data base. A comment included in one of the two audit tools provided stated, "multiple risk assessments and precautionary status documents for the girls…lacked a psychologist signature…Dr. Hamning contacted me…and stated this problem had been rectified in full." The second document, the compliance summary was also undated. It noted that contrary to the requirements for a 10% sample noted above, the sample size was three. This document reported 100% compliance in the five areas.
Recommendations	. Determine the status of policy and procedure regarding suicide prevention. . Continue quality assurance efforts regarding suicide prevention. Quality assurance documents must be dated and include a representative sample of all youth. . Ensure that youth requiring precautionary status are identified and

	monitored. . Determine the need for additional mental health intervention for that subset of youth requiring frequent precautionary status.
Evidentiary Basis	1. Review of policy and procedure. 2. Review of provided quality assurance information 3. Review of the list of youth requiring suicide watch status. 4. Staff interview

17.	**Transition Planning: The State shall ensure that staff create transition plans for youth leaving the Facilities consistent with generally accepted professional standard of care.**
Discussion	Per a meeting with key facility staff regarding the facilities progress regarding the requirements of the agreement, the facility was reportedly; "in the infancy stages of transition planning…we need to work with social services staff regarding the development of a discharge plan and focus on establishing links with community providers." Staff indicated a shift in their approach to transition planning, specifically, "we are trying to look at discharge planning from the date of admission." In response to a document request for transition plans for the last ten youth prescribed psychotropic medication discharged from the facility, the monitor was provided with medical release summary documents for the youth, as well as the psychological services summary form. When reviewing these documents, it was noted that there were some medical release summaries dated prior to the previous monitoring tour, these were not reviewed with regard to compliance. A review of more recent documentation revealed improvements in the documentation included in the medical release summaries. For example, the medical release summary of youth 111 revealed a listing of psychotropic medication, documentation of a 30-day supply of medication, and a listing of diagnoses. What was concerning, and indicative of other challenges in the mental health system at the facility, was despite a two year incarceration, the youth's psychiatric diagnoses included two rule outs, signaling that a diagnostic assessment was not finalized. With regard to a follow up appointment, nursing indicated that the youth's mother was "waiting on a call from the office." Per the psychological services summary dated 1.25.11, transition planning included, "youth appears…to need a high level of wrap around services in the community. Follow up in the community will be necessary based on his history of medications…will require assistance in obtaining his…education…based on his lack of desire to participate while here…appearing to struggle toward the end of his stay and staff reported concerns about him just prior to his release…" Despite these concerns regarding this youth's mental health status and history of significant mental health symptoms, no other documentation of mental health referrals or linkages to community supports was documented. Per the medical release summary of youth 222, dated 10.26.10, a listing of medications and diagnoses was documented. There was no documentation regarding the amount of medication the youth was prescribed at discharge (either in actual medication or via prescription). The document did not note

	the requirement for psychiatric follow up after release from the facility. Per the psychological services summary form dated 10.27.10, " she should continue to work with the psychiatrist…community psychiatrist have been [sic] contact to continue care upon r elease…mother indicated she would facilitate medication management while in the community…in her therapy…continue to address the thinking and choices that lead to aggressive and assaultive behavior…she should receive help to develop people in the community who can be a support for pro-social thinking and behavior…" Despite these recommendations, no notations regarding how the youth would link with these community services, or with whom or where her follow up ps ychiatric appointment or therapy was scheduled were noted. These above examples are similar to those documented in the previous monitoring report, where recommendations were made, and the need for community linkages and appointments was clear, but there were no resources documented. Given the facility staff's verbal self-assessment documented above, it was apparent that they were aware of the to develop transition planning services at the facility to include linkage with community resources. 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. Per the facility verbal self-assessment, the policy and procedure entitled "Behavioral Health Services" was finalized and implemented. A review of a subsection of this policy entitled "Discharge Planning" revealed a requirement that "for all youth placed on a mental health caseload, or who resided in a special services living center…a staffing shall be held to discuss clinical recommendations after a youth is released…based on the recommendations of the staffing team, a psychologist or assigned psychology assistant shall complete…discharge summary." A review of the provided transition planning documentation revealed one example of the discharge summary documentation dated 1.12.11 regarding youth 333. It was noted that the diagnoses at the tie of discharge documented on the discharge summary were different from those noted on the medical release summary. This example was missing two critical pieces of information as the sections of the form entitled "continuity of care/referral information" and "after care options" were not included.

Recommendations	Development of community linkages and resources. Ensure that all sections of the discharge summary form are included and completed. Continue to begin discharge planning at the time of admission. Begin quality assurance monitoring regarding the documentation of discharge information and the integration of this information with the medical release summary. Ensure that all youth (not only those who are mentally ill) receive transition services and linkages to appropriate community services.
Evidentiary Basis	. Review of ten medical release summaries . Review of ten psychological service summaries used as part of transition and discharge plan . Review of one discharge summary . Review of relevant policy and procedure . Staff interview

18.	**<u>Oversight of Mental Health Services</u>: 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.**
Discussion	Per a meeting with facility leadership during this monitoring review, policy and procedure regarding Quality Assurance and Clinical Supervision had been implemented. A review of these two policies revealed effective dates of January 1, 2011. As required by the newly implemented policy, the initial facility quality improvement meeting was held February 8, 2011. Unfortunately, minutes from this meeting were not included in the documents provided. Included in the document request were quality assurance reviews regarding "Integrated Treatment and Service Delivery." A review of this document revealed an eight-page report that was not dated, so it was impossible to determine the date or time period of review. There were multiple headings of subject matter reviews entitled: Individual Treatment Planning, Interdisciplinary Teams, Individual and Group Sessions, Suicide Prevention and Response, Substance Abuse Assessment and Service Delivery, Sex Offenders Assessment and Planning, Recreational Programming, Mental Health Screening and Appraisals, Mental Health Professional Guidelines, Mental Health Classification, Mental Health Referrals and Services, Mental Health Transfers from Reception and Facilities, Mental Health Treatment Plan, Transition, and Family Contact. Below each of these headings were a listing of standards, however, the document did not define what the standards were, nor was a copy of the guiding document defining the standards provided. As such, it was impossible to determine compliance with specific areas. It was notable that despite knowledge of the requirements for the individual parameters, this document was informative. There were a majority of areas where compliance percentages as assigned by the facility reviewers were less than 70%. For example, regarding Individual Treatment Planning seven items were reviewed. Of these seven items, one was documented at 100%, the remaining six were rated at below 68%. Of those six, it should be noted that two items were rated at 0% and two items were rated at 12%. As it was impossible to determine the specific requirements for each individual rating, an average rating for each subject was calculated (*percentages were not available for items entitled Mental Health Professional Guidelines, Mental Health Referrals and Services these were*

reported as compliant or non compliant). It was also noted that the document indicated eleven separate action plans would be generated. The areas were action plans were authored are noted with an asterisk:

Subject	Number of Items	Average Compliance Rating
Individual Treatment Planning*	Seven	35.4%
Interdisciplinary Teams*	Seven	67.75%
Individual and Group Sessions*	Six	65.8%
Suicide Prevention and Response	Five	100%
Substance Abuse Assessment and Service Delivery*	Three	82.6%
Sex Offenders Assessment and Planning	Two	33%
Recreational Programming	Four	100%
Mental Health Screening	Four	71.5%
Mental Health Classifications*	Three	93%
Mental Health Transfers from Reception and Facilities*	Three	85.6%
Mental Health Treatment*	Six	76.8%
Transition*	Three	0%
Family Contact*	Six	44.2%

Additional information provided regarding quality assurance and clinical supervision revealed a performance review for one mental health provider dated 12.15.10. There was no documentation provided regarding regular clinical supervision of providers. Other information provided regarding

	quality assurance revealed social services weekly report. What was striking regarding this social work documentation (and discussed during the monitoring tour) was the apparent lack of commitment on the part of a small subset of staff, to the overall mental health treatment program. There was documentation of multiple missed group therapy sessions, and although a percentage of these were rescheduled and "made up" there was cause for concern regarding a lack of investment by treatment staff. Per the weekly report for the week ending January 10, 2011 it was noted that a specific provider did not have any documentation of individual sessions with youth documented in the case notes for the previous month. For the week ending December 20, 2010, it was reported that there were no individual sessions regarding youth 111 for the previous week. This is especially concerning given this youth's serious mental health issues which as stated above in this monitoring report led the treatment team to place him in isolation without time out of his room for a period of four days. During this monitoring tour, it was evident that staff were working diligently to implement treatment modalities in an effort to both provide necessary services to the youth and to satisfy the requirements of the settlement agreement. There were areas, however, where implementation was just beginning. For example, the Behavioral Health Review Panel had been piloted, beginning with those youth admitted on Tuesdays. There were plans to expand this review panel to include all admissions beginning 4.1.11. During this monitoring tour, the first trauma groups were held on the mental health units (both male and female units). Training was in process for staff regarding cognitive behavioral therapy (CBT). The facility staff indicated 4.1.11 as the date for the full implementation of CBT across campus. Given this recent surge in mental health treatment (i.e. development of a framework) and actual service provision, quality improvement monitoring may be slightly premature. Staff interviewed revealed that they are "keeping lots of statistics, but there is no system to accurately manage data…and the analysis of the data will come later." Staff indicated that they have created a database for quality assurance information, and have hired a data manager. With regard to the current mental health policies and procedures in effect, it was difficult to determine the adequacy of these documents based on only partial implementation. Policy and procedure must be reviewed and revised on a periodic (e.g. annual or more frequently as needed) basis in order to ensure that the written document adequately reflects actual facility practice and vice versa. In addition, quality assurance measures regarding outcomes based on policy implementation will be beneficial in determining adequacy

	of the current procedures. The quality assurance documentation reviewed in preparation for this monitoring report was below par, in that as stated above, it was not dated; it was impossible to determine the requirements for each individual parameter; and per interviews with facility staff as well as observation of practices, policy and procedure had not been fully implemented.
Recommendations	. Complete staff training and implement planned mental health administrative structure, meetings and treatment modalities. . Following the full implementation of these programs, begin quality assurance monitoring to assess the efficacy of staffing, treatment and interventions. . When providing quality assessment results, date the document and describe the standard being monitored in the document.
Evidentiary Basis	. Staff Interview . Review of the provided documents.

Attachment D

United States of America v. The State of Ohio
Case No. 2:08-cv-475

Review of the Scioto Juvenile Correctional Center Medical Care

Dr. Michelle Staples-Horne

April 05, 2011

Dr. Michelle Staples-Horne has been the Medical Director of the Georgia Department of Juvenile Justice since 1994 and is responsible for the provision of medical services to over 1900 youth each day in 28 facilities served by the Department. She received her Medical Degree from the Morehouse School of Medicine and her Master of Public Health in Health Policy and Management from Emory University in Atlanta. She holds both a Bachelor of Science Degree and a Master of Science Degree in Biology from Clark Atlanta University with research experience in Biochemistry and Microbiology. She also is a Certified Correctional Health Care Professional (CCHP) by the National Commission on Correctional Health Care. Her clinical experience includes training in Pediatrics at Columbia University's Babies Hospital in New York and Preventive Medicine at Morehouse School of Medicine. She has provided clinical services on a part time basis as an adolescent health physician for the Fulton County Department of Health and Wellness for the past 18 years

Dr. Staples-Horne is a current member of the Health Care Committee of the American Correctional Association (ACA) and the Juvenile Health Committee of the National Commission on Correctional Health Care (NCCHC). She is Past President of the Society of Correctional Physicians. She has provided correctional health care consultation and training in several states as well as for the National Institute of Corrections and the Centers for Disease Control and Prevention. Dr. Staples-Horne assisted the Arizona Department of Juvenile Corrections in development of an electronic medical record and policy development. She consulted with the American Correctional Association on an assessment of the Texas Youth Commission. She has conducted several compliance audits for the NCCHC and has served as an expert witness for the plaintiff in two legal cases.

Dr. Staples-Horne is also the author of several standards, guidelines, articles and book chapters relating to correctional health care. She participated in the CDC/HRSA funded Demonstration Project to provide GC and CT screening and education to thousands of DJJ youth admitted to the Metro Regional Detention Center. She is currently involved with a National Institute on Alcohol Abuse and Alcoholism (NIAAA) grant (Project RHAPS) to conduct an alcohol and drug related HIV risk reduction intervention for male adolescent detainees (MADS) within the Georgia Department of Juvenile Justice. Dr. Staples-Horne is also a participant in the Adapting *SiHLE* for Recently Detained African American Adolescent Females (METRO Study). This study will adapt an effective intervention (*SiHLE*), which is designed to promote HIV preventive sexual behaviors among African American adolescent females recently discharged from youth detention centers. Dr. Staples-Horne has provided training to students and health professionals through teaching and presentations at numerous health care and correctional conferences.

Ohio Department of Youth Services
Scioto Facility Follow Up Report
Submitted by Dr. Michelle Staples-Horne
April 4, 2011

I. GENERAL MEDICAL CARE

C.1 *GENERALLY*

> *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.*

A request was made in January, 2011 for additional documentation for review by this subject matter expert in order to assess continuing compliance with the U.S. Department of Justice requirements. Specific documents were requested this time to address concerns or questions established during the last health record review reported on January 8, 2011. Twelve health records were provided by the Ohio Department of Youth Services for review off site, as well as staff training records, and status updates on the electronic health record and health policies as requested.

No health care policies have been added or updated since the last review. Ohio Department of Youth Services reported that two thirds of their current health care policies were approved and implemented on 3/31/2010 and were currently in the annual review process. Approximately one third of the health policies including quality assurance were reported to be awaiting final approval.

Since staffing often dictates the level of care youth receive, a list of total health care positions at the facility by FTE count was requested to include RNs, LPNs, physicians, mid-level staff and all dental staff, including the dentist. The following response was submitted:

One (1) HEALTH SERVICES ADMINISTRATOR
One (1) ADMINISTRATIVE ASSISTANT 2
Two (2) MENTAL HEALTH REGISTERED NURSES
One (1) HEALTH INFORMATION TECH/PHLEBOTOMIST
Eleven (11) REGISTERED NURSES STAFFING THE CLINIC
One (1) REGISTERED NURSE FOR RECEPTION
One (1) LICENSED PRACTICAL NURSE FOR RECEPTION
One (1) LICENSED PRACTICAL NURSE STAFFING THE CLINIC

For Scioto Juvenile Correctional Facility this totals fourteen (14) Registered Nurses and two (2) Licensed Practical Nurses. The Health Services Administrator is also a Registered Nurse. This staffing pattern could provide coverage with at least 3 registered nurses on the first and second shift and 2 nurses on the third shift, 7 days a week, without including the Health Services Administrator in any direct patient care responsibilities.

In addition to the nursing staff, clinical staff included:

One (1) PHYSICIAN SERVING THE MALE POPULATION
One (1) PHYSICIAN SERVING THE FEMALE POPULATION FOR GENERAL MEDICAL CARE.
One (1) DENTIST
One (1) DENTAL HYGIENIST
One (1) DENTAL ASSISTANT
Two (2) OB/GYN M.D.'S
Two (2) OB/GYN D.O.'S
One (1) CERTIFIED MIDWIFE
One (1) OPTOMETRIST
One (1) PSYCHIATRIST

The schedule for the above clinical staff was also submitted for review. The two primary care physicians provided coverage each day of the week, except Wednesday and Sunday, for a combined total of approximately 1 FTE. The psychiatrist saw youth 7 hours each on Tuesday, Thursday and Friday. OB\GYN services were provided 3 hours a week by 5 rotating providers. The Optometrist saw youth the second and third Friday of each month. It appears from review of the health record that these hours provide adequate clinic coverage and access to care and treatment of youth. Dental staffing is addressed in section C7 Dental Care.

At the last documents review reported in January 2011, the training curriculum was appropriate and adequate to address the general care of juvenile detainees at Scioto, but few were specific to medical staff training. No documentation of health care provider continuing education was submitted for review. I requested training records specific to health staff for this review. Training records were submitted for 14 nurses and one phlebotomist. Although the training documentation was exhaustive, it still primarily consisted of courses relevant to the general correctional staff. Examples included Managing Youth Resistance, Information Technology, Cultural Competency, Planned Intervention, etc. No evidence of continuing education training specific for health care professionals was submitted.

Intake screenings upon admission were completed in 100% of the charts reviewed. Physical examinations were completed by the facility Pediatrician and gynecological examinations by the facility Gynecologist in all cases. Females received gender specific health services such as pelvic examinations, family planning and pregnancy related services.

Sick call requests were appropriately addressed and documented in the health records reviewed. There was a concern expressed by youth during the last site visit that some requests were not being addressed. This concern is addressed more thoroughly in section C5. Access to Health Services. Injury assessments

are being completed in a timely manner. There was one emergency response documented that occurred on site at the facility included in one of the health records

Youth with chronic medical conditions were provided excellent care (see C8 for details). Youth continued to receive appropriate diagnostic services such as laboratory and radiology in a timely manner. Preventative services continue to be reflected by immunization administration updates, including influenza vaccination and dental prophylaxis. There was documentation of health education provided to youth in their health records including dental hygiene education.

ODYS policy 403.08, Section VI Monitoring requires that ongoing reviews shall be conducted by the designated Interdisciplinary Team on a quarterly basis as a part of the Department's Continuous Quality Improvement (CQI) process. No additional evidence was sent to me that CQI is occurring, other that a roster of medical staff receiving Quality Improvement training on 5/21/2010 that was provided during the last review. Although a quality assurance component was not specifically included in the DOJ requirements, it is an essential part of any medical program that aims for continuous quality improvement. Doing such through a structured format will keep the medical program compliant with national standards.

As evidenced by the twelve scanned health records reviewed, medical care received by youth at Scioto is adequately being provided consistent with current professional standards to include routine, preventative and emergency care. Youth health records reflect routine care through a thorough and consistent intake screening process including initial medical, dental, and mental health assessments.

Status: Maintained staffing levels, but no improvement in staff training. Other requirements of this provision were maintained at the previous level.

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.*

Policies and Procedures were updated March 31, 2010 identifying required components of the medical record, and addressing the requirement of records confidentiality and transfer adequately. No further policy updates were submitted for review. Health records continued to be formatted according to policy. Allergies were consistently noted within the health record.

Scioto still does not currently combine mental health psychological and medical records into one health record, such as was the case during the last review. Psychiatric evaluations and chronological psychiatric progress notes were included, but no psychological records such as case notes were included in the

health record. Progress notes indicated that youth were participating in groups, but did not include details within the health record. These are most likely still being documented in a separate psychological record. Merging documentation of the two records creates a large health record, which could involve several volumes. The best solution is to implement the electronic health record, so that all documentation exists in one record without the bulk of a physical record. The electronic health record has not been implemented. The Ohio Department of Youth Services reports collaborating with Ohio State University to explore the EPIC electronic health record program that is currently being used by the Ohio Department of Rehabilitation and Corrections.

During this review, problem lists were documented in each health record that included both medical and mental health diagnoses. There was adequate documentation on the transfer of medical information included in the review of the health records. The nurses did an excellent job of documenting communication regarding transferring care of youth to outside health providers and notifying parents and probation officers of the need for follow up care in the community.

Status: Maintained without further progress in development of health policies, electronic health record, or combination of psychological records into the youth health record.

C.3 *CONFIDENTIAL HEALTH CARE*

No expansion of current Policy 403.04, Medical Facilities, Equipment and Supplies was made to include the language in the provision requiring placing of non-medical staff out of the line of sight and hearing of the health assessment, except in circumstances where documented safety considerations posed by a particular youth require enhanced, non-medical supervision. During the recent DOJ site visit youth did not express concern over confidentiality of health care.

Status: Maintained practice but no policy development.

C.4 *INITIAL HEALTH ASSESSMENT*

> *The Facilities shall ensure that initial health assessments are complete and include: use of growth and weight charts; laboratory test results placed in the youth's health records before the youth is transferred out of reception; results of all laboratory tests, to be provided for each test within 20 days of its performance; testing of all youth for sexually transmitted diseases; and a problem list and a plan of care for each problem identified at reception.*

Each of the 12 health records reviewed included an initial health assessment, physical examination, and growth chart. Timely laboratory results, including sexually transmitted diseases were documented in all the health records. All lab tests results were on the chart usually within 10 days of its performance. Tuberculosis, vision and hearing screening results were consistently documented. Each record included STD testing results. Problems identified on the initial health assessment were followed up by health care staff. Improvement has been made on making the problem list more inclusive of all diagnoses. The

health records consistently included the mental health diagnoses in this review compared to the previous review. Only one outlier chart missed listing one major medical diagnosis on the problem list.

Status: Improved

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.*

Sick Call Policies and Procedures were reviewed and updated by ODYS in March of 2010. Prior to that time, policies were last updated in 2006 and 2007. Policies and Procedures should be reviewed at least annually and updated as needed. This policy should have been due for review in March 2011.

During the DOJ compliance tour of February 22-24, 2011, numerous youth alleged that they were waiting three or more days to be seen for sick call. One youth alleged their sick call complaint was never answered and one youth complained of a 2 complaints not answered timely. These complaints were documented in the US V Ohio Post Tour letter of March 11, 2011. It is difficult to assess whether or not these allegations are true based on the documentation in the twelve health records reviewed. There were relatively few sick call request forms completed by youth in their medical record compared to the number of assessments completed for medical complaints documented in the progress notes. Of the twelve health records reviewed, two did not contain any sick call request forms and one record had only one hand written request. Youth may not be submitting many sick call requests or the sick call request forms are not being placed in the health record. Another explanation may be due to nurses being approached by youth directly with medical complaints, such as while they are passing medications on the units and a sick call form is not completed. There was one such case documented in the progress notes of one youth that complained of a toe injury while the nurse was on the unit. She was evaluated by the RN on the unit, later that day brought to the clinic for further evaluation and followed up in clinic the next day. Youth are being seen in a timely manner according to the date on the sick call request form, usually the following day. Youth are frequently referred when appropriate from the nursing staff to the physician. The physicians saw youth and documented on all the records reviewed. A minor surgical procedure was completed by the physician to incise and drain a boil in one case. One youth complained of ear pain one day, was seen by the nurse the next day, given Tylenol for pain and referred to the physician. Youth was seen the following day by the physician, diagnosed and treated. In all cases, according to the health records, more youth medical complaints were being addressed than the number requested through sick call requests.

Status: Maintained according to review of health records, however during site visit some youth had expressed some decrease in access to sick call.

C.6 *MEDICATION MANAGEMENT*

The Facilities shall not discontinue a chronically ill youth's usual medication for non-medical reasons, including that the medication is not on the Facilities' formulary.

Medications were continued for youth with chronic medical conditions. Medication administration records were documented thoroughly that youth were receiving their medications. Progress notes documented treatment refusals made by youth. Chronically ill youth that arrive with medications at the facility are continued as ordered upon timely review by the facility physician. Prescriber's orders for medications and medication administration records are complete and in all the youth health records. Medications are being administered and documented by nurses as ordered. Consents for psychotropic medications are present in the youth record where applicable. Hot weather precautions were included for youth on certain medications predisposing them to heat sensitivity. Abnormal Involuntary Movement Scale (AIMS) were also documented for youth on psychotropic medication.

Status: Maintained

C.7 *DENTAL CARE*

The Facilities shall ensure that:
Dental restorative needs are listed on a dental treatment plan for the youth, tracked by the dental program, and treated on a timely basis consistent with generally accepted professional standards of care;
b. Prosthetic dental services are provided based on need, as determined by the treating dentist, with appropriate consideration for the replacement or repair of missing front teeth, according to generally accepted professional standards of care;
c. Youth experiencing dental pain are not denied adequate pain medication;
d. Health records contain adequate documentation of all outside dental consults, including the clinical examination, treatment plan, procedures performed, orders for management after the procedures, and any follow-up appointment or plan; and
e. Dental staffing is adequate to meet the restorative dental needs of the Facilities' populations.

Statistical data for dental services was provided for review. The dental hygienist works up to 16 hours/week and averaged 1-2 dental prophylaxis/hour. The dentist and dental assistant work up to 30 hours/week and completed an average of 97 examinations and 34 restorations per month. Dental staffing appears to be adequate; however, there was a downward trend in the number of youth examined between September and December 2010 compared to the previous months of the year. Each youth examined received 3-4 dental x-rays each. Appropriately, far more restorations were completed than extractions. There was documentation in the health record that youth were receiving sealants, appropriate dental referrals were being made and dental prostheses (night guards) were being provided. Youth experiencing dental pain were seen by the nurse and given pain medication until seen by the dentist, usually the

following day. One youth, NH, had more than one sick call request complaining of dental pain. The nurse documented in the progress note that the youth had admitted that she had seen the dentist, but refused to get fillings because she was afraid of needles.

Status: Improved

C.8 *MANAGEMENT OF CHRONIC ILLNESSES*

The Facilities shall ensure that:

a. Chronic disease policies, protocols, and practices are appropriate for chronically ill adolescents;

b. Youth with chronic asthma are continued on their established medicines on admission unless the youth's condition warrants a change in treatment; and

c. Youth who frequently use rescue inhalers are appropriately monitored and treated by physicians to minimize preventable asthma hospitalization resulting from acute respiratory crisis that follows an inadequately treated exacerbation of chronic asthma.

Cases of youth were identified and treated appropriately for hypertension, seizure disorder, hypothyroidism, renal disease, asthma, hepatitis C, latent tuberculosis, and a cardiac condition. Health records were also reviewed for the care and treatment of two pregnant females. One pregnant girl's care was particularly a challenge due to additional diagnoses of hypertension, renal disease and asthma. Prenatal care was provided using the community standard of care (ACOG). The youth with hepatitis C received extensive education on her disease, liver ultrasound studies, appropriate laboratory tests and immunizations. There were four youth whose records indicated a history of Asthma. Three of the cases were mild and only required use of an inhaler as needed. However, one of these youth did experience an exercise induced asthma attack and required use of the inhaler imminently. KS's medication order was changed to allow use of the inhaler prior to exercise. The other youth had severe persistent asthma with numerous past hospitalizations requiring multiple medications. This youth was well managed by the health care staff including continuing outside allergist consultation visits for Xolair medication injections. Excellent continuity of care occurred for youth with chronic diseases. Medical records from community providers were included in the health record as well as care plans documented for when youth were to be released back into the community.

Status: Maintained

C.9 *ACCESS TO SPECIALTY CARE*

Absent clinically justified rationale, the Facilities shall not withhold access to specialist services recommended by a treating physician and shall ensure that: prior approval of specialty medical consultations is made by a physician trained and qualified in pediatrics and adolescent medicine; and assessment

criteria for the necessity of specialty consultations are based on pediatric and adolescent medicine.

Upon review of the heath record, youth continued to have access to specialty care. Referrals are being made appropriately by the facility pediatrician and family practice physician. Optometry care was provided and glasses purchased routinely when youth failed the vision screening. Youth received appropriate outside consultations with Nephrology, Cardiology, Neurology and Obstetrics specialists in the health records reviewed. Other diagnostic studies such as x-rays, ultrasounds, EKGs, and other studies were provided as appropriate.

Status: Maintained

C.10 *IMMUNIZATIONS*

The State shall make reasonable efforts to obtain immunization records for all youth who are detained at the facilities for more than one (1) month. The State shall ensure that medical staff update immunizations for such youth in accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a youth is medically inappropriate shall properly record such determination in the youth's medical record.

As in the previous health record review, youth in general were receiving appropriate immunizations including HPV and influenza vaccine. Immunization records were included in all 12 health records except one, where the youth had only recently been admitted to the facility. Only one youth, SM, was not brought current on her immunizations although her previous immunization records were in the health record. Immunization policies have not been updated.

Status: Maintained in 11 of 12 health records